WOLFVILLE NATUROPATHIC CLINIC INC

Pediatric Intake Form (Birth to Age 11)

Child's name_____ Age_____ Date & Place of Birth_____ Sex at birth_____
Full Address_____ Phone_____
Full name of Mother/Guardian _____ Occupation_____
Home Phone _____ Cell Phone _____ Email_____
Full name of Father/Guardian _____ Occupation_____
Home Phone _____ Cell Phone _____ Email_____
Please indicate any special living arrangements your child may have_____
Emergency Contact/Number_____ Emergency Contact/Number_____
Names of siblings & ages _____
Family Physician_____ Other Health Care Practitioners_____
How did you hear about this clinic?_____

Health Concerns (in order of importance)?

1. **2.** **3.**

4. **5.** **6.**

Medical History

Date of last physical exam_____ Height_____ Weight_____ Blood Type_____
Current Medications and Dosages_____
Past Medications_____
Does your child have any allergies?_____ To what?_____

Please circle which vaccinations your child has had*: Tetanus Pertussis Diptheria Polio Measles Mumps Rubella Varicella Hepatitis B Influenza Other*_____
Please note any reactions to these vaccinations (fever, etc)_____

Please list all major accidents, hospitalizations, surgeries, diseases and traumatic events, and your child's age at the time:

Event	Age	Event	Age
1.		2.	
3.		4.	
5.		6.	

Please continue on the back of this page if you require additional space.

Family Medical History

Does anyone in your child's family have a history of the following or other relevant conditions? Please use the back if necessary to describe:

Asthma/Allergies Cancer Diabetes Eczema/Psoriasis Kidney disease Autoimmune disease Anemia Anxiety/Depression

Prenatal/Pregnancy History

•**Biological Mother** (where possible)

Age of mother at conception_____ Mother's health at the time (please circle) *Excellent* *Good* *Fair* *Poor*

Medications/Supplements taken at conception and during the pregnancy _____

Was this a particularly emotional time for the mother? (Explain)_____

Please circle which of the following the mother experienced during the pregnancy: *Nausea* *Vomiting* *Bleeding* *Diabetes* *Thyroid Problems* *High Blood Pressure* *Pre-Eclampsia* *Eclampsia* *Physical Trauma* *Emotional Trauma* Other_____

Were cigarettes, alcohol or recreational drugs used?_____ Which/How often?_____

•**Biological Father** (where possible)

Age of father at conception_____ Father's health at the time (please circle) *Excellent* *Good* *Fair* *Poor*

Medications/Supplements taken by the father at the time of conception_____

Was this a particularly emotional time for the father? (Explain) _____

Labour History

Place of Birth_____ Vaginal Delivery or C-Section?_____ Length of Labour_____

Was the pregnancy (please circle): *Full term* *Premature* *Past term* Were there any complications?_____

Were any medications/interventions used? (ie pitosin, forceps, etc)_____

Neonatal History

Weight_____ Length_____ APGAR scores_____ Any concerns at birth?_____

Was this child breast-fed?_____ Until what age?_____ Were there any feeding problems?_____

Please indicate the approximate age at which the following were introduced: *Formula & Type* _____

*Fruit*_____ *Vegetables*_____ *Soy*_____ *Milk*_____ *Eggs*_____ *Wheat*_____ *Meat*_____

Please explain any adverse reactions_____

Development and Social Interaction

Do you feel that your child was delayed in reaching any of the following milestones (please circle)? *Holding head* *Smiling* *Rolling over* *Sleeping through the night* *Sitting* *Crawling* *Speaking* *Walking* *Toilet Training* *Reading* *Writing*

Do you feel that this child is growing at an acceptable rate physically, mentally, and emotionally? (Explain)_____

_____

Has your child ever been evaluated for (please circle*)* *Hearing* *Speech* *Language* *Other* Explain_____

How would you describe your child's academic achievement?_____

How would you describe your child's social interaction with peers?_____

Does your child throw tantrums or have any destructive or odd interests which concern you? (Explain)_____

_____

Does your child suffer from any of the following (please circle) *Nightmares* *Daydreaming* *Nervousness* *Moodiness* *Unusual Fears* *Easy crying* *Separation anxiety* *Sleepwalking* *Hyperactivity* *Memory loss* *Fainting* *Seizures*

Explain_____

Has this child ever been a victim of mental, emotional, physical or sexual abuse?_____

Environment

Are there any pets in the child's home?_____ Does he/she have seasonal allergies? _____

Is he/she affected by any of the following? (Please circle) *Perfumes* *Molds* *Trees* *Grasses* *Weeds* *Molds* *Dust* *Animals*

Do your child live/sleep in a Basement?_____Near a farm?_____ On a farm?_____

Approximately what year was your child's home/ dwelling built?_____ How is it heated?_____

Do you use chemicals on your lawn/garden?_____ What is your source of drinking water?_____

Is your child exposed to any chemicals/hazardous materials on a daily basis?_____

Can you think of anything in your child's home/school environment which might adversely affect his/her health (Explain)_____

_____

Is there anything else that you feel I should know about your child? (Please use the back of this page if necessary)