NATURALLY GOOD HEALTH CLINIC
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Pediatric Naturopathic Intake Form

Welcome to Naturally Good Health Clinic. The pediatric health questionnaire provides valuable information on the factors which contribute to the underlying causes of your child's health concerns. Please fill out the questions to the best of your ability and bring the form in with you to your first visit to our wellness centre.

GENERAL CONTACT INFORMATION

Child's Name: _____
(*last name*) (*first name*) (*middle initial*)

Age: ____ **Gender:** □ Female □ Male **Date of Birth**: _____ /_____ /_____
DD MM YY

Address: _____
(*street address*) (*city*) (*province*) (*postal code*)

Parent/Guardian Name(s): _____

Telephone: Home _____Work _____ ____Cell _____

May we leave messages on your phone line? ____ Preference (circle all applicable): Home/ Work/ Cell

Email: _____

Person completing this form (name and relationship)_____

Who does the child live with? _____

How did you hear about this clinic? _____

Emergency Contact: _____
(*name*) (*relationship*) (*telephone*)

Primary physician _____ **Last physical exam** _____
(*name*) (*telephone*) (*month*) (*year*)

Please list any additional health care providers with their designation and contact information:
_____

PLEASE COMPLETE THE FOLLOWING QUESTIONS

What are your child's main health concerns? List as many as you can in order of importance.

1) _____

2) _____

3) _____

4) _____

5) _____

Please list any past / current prescription medications, over the counter medications, vitamins, herbs, homeopathic or other supplements your child has / is taking, the dosage and how effective you have found these treatments:

1) _____

2) _____

3) _____

4) _____

5) _____

Approximately how many times has your child been treated with antibiotics? _____

Is your child hypersensitive or allergic to any of the following (please list):

Drugs? _____

Foods? _____

Environmental? (e.g. pollen, dust, perfume) _____
_____

Please describe what type of reaction your child experiences with an allergy attack?
_____

_____

Has your child had any specific allergy testing? If yes, please explain: _____

Does your child have a medic alert?_____

MEDICAL HISTORY

List all surgeries your child has had:
_____year? _____ purpose? _____
_____year? _____ purpose? _____
_____year? _____ purpose? _____

Are there any traumatic events (surgeries, drug reactions, serious illness, accidents etc.) that you feel may have caused or contributed to your child's health problems?
_____

Has your child ever been to the emergency room? If so, what was it for?_____
_____

Environmental Toxic Exposure

Has your child ever been exposed to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals (lead, mercury, cadmium etc) while at work, home or travelling?	Y	N
Does your child live near power lines or a refinery?	Y	N
Is your child's home and school environments well-ventilated?	Y	N
Is your child exposed to significant tobacco smoke (home, etc.)?	Y	N
Is your child frequently exposed to animals (pets, etc.)?	Y	N
Does your child have mercury dental fillings?	Y	N
Does your child have any surgical implants (medical, cosmetic)	Y	N
Does your child have any body piercings?	Y	N
Has your child ever had any organ transplants?	Y	N

Has there been an event or sickness that your child has never fully recovered from? Please indicate below

_____

Please check all vaccinations your child has had:

DPT (diphtheria, pertussis, tetanus)	□	Hib (Haemophilus influenza B)	□
D-PTP (diphtheria, pertussus, tetanus, polio)	□	Hepatitis B	□
MMR (measles, mumps, rubella)	□	Smallpox	□
OPV (Polio)	□	Td + P (tetanus, diphtheria, polio)	□
Flu	□	Other	□

Has your child experienced reactions to their vaccinations? Please explain:
_____
_____

Has a sibling of the child experienced an adverse reaction to any of their vaccinations? Please explain:
_____

TYPICAL FOOD INTAKE

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages: _____
Cravings: _____
Aversions: _____

Do you add **salt** to your child's food? □ Yes □ No

How many **cups / day** does your child drink of the following?
Pop ___ Fruit juice ____ Herbal tea ___ Cow's Milk_____

How many glasses of **water** does your child drink per day?
Tap____ Filtered_____ Distilled____ Reverse Osmosis _____Spring____

What temperature of liquid does your child prefer to drink? (circle) hot cold room temp.

Does your child have any dietary restrictions (religious, vegetarian, vegan etc.)?
_____

Are you satisfied with your child's diet the way that it is now? Why or why not?
_____
_____

GENERAL

Weight _____ Height _____ Blood Type _____

FAMILY HISTORY

Please check any of the following conditions that have occurred in your family (grandparents, parents, siblings).

Allergies	_____	Eczema	_____
Anemia	_____	Heart Disease	_____
Asthma	_____	Juvenile Arthritis	_____
Autoimmune disease	_____	Kidney Disease	_____
Birth defects	_____	Mental illness	_____
Bleeding disorder	_____	Seizure/Epilepsy	_____
Cancer	_____	Stroke/Aneurysm	_____
Crohn's or colitis	_____	Thyroid condition	_____
Diabetes	_____	Tuberculosis	_____

Other _____

SYMPTOM CHECKLIST

Please take a moment to circle the following symptoms and childhood illnesses which your child may have experienced either in the past, or presently.

Symptom Checklist	**Past**	**Now**
Appetite change	□	□
Bad breath	□	□
Bed wetting	□	□
Burning urination	□	□
Chronic bleeding nose	□	□
Chronic bruising	□	□
Chronic runny nose	□	□
Colic / gas / cramping	□	□
Constipation	□	□
Cough	□	□
Cradle cap	□	□
Cries easily	□	□
Diarrhea	□	□
Diaper rash	□	□
Difficulty concentrating	□	□
Difficulty sleeping	□	□
Dizziness	□	□
Easy bruising	□	□
Eczema / Hives	□	□
Fatigue	□	□
Hair loss	□	□
Headaches	□	□
Hearing loss	□	□
Indigestion	□	□
Insomnia	□	□
Nervousness	□	□
Nights sweats	□	□
Sore throat	□	□
Stomach aches	□	□
Temper tantrums	□	□
Urinary frequency	□	□
Visual disturbances	□	□
Vomiting	□	□
Wheezing	□	□
Other: _____		

Childhood Illnesses	**Past**	**Now**
Acute epiglottitis	□	□
ADHD / ADD	□	□
Allergies	□	□
Anemia	□	□
Appendicitis	□	□
Asthma	□	□
Autism	□	□
Bronchitis	□	□
Cancer	□	□
Chicken pox	□	□
Cold sores	□	□
Conjunctivitis (pink eye)	□	□
Congenital diseases	□	□
Diabetes	□	□
Frequent colds	□	□
Fevers	□	□
Head lice	□	□
Impetigo	□	□
Measles	□	□
Meningitis	□	□
Mononucleosis	□	□
Mumps	□	□
Pneumonia	□	□
Recurrent ear infections	□	□
Rheumatic fever	□	□
Rubella	□	□
Scarlet fever	□	□
Seizures	□	□
Sinusitis	□	□
Thrush	□	□
Tonsillitis / Strep throat	□	□
Urinary tract infections	□	□
Whooping cough	□	□
Other:_____		

Bowel Habits

Frequency of stool_____ times per day_____ times per week_____

HEALTH HISTORY FROM BIRTH

Health of parents

Inquiry	**Excellent**	**Good**	**Fair**	**Poor**	**Unknown**
Health of mother at time of conception					
Health of father at time of conception					
Health of mother during pregnancy					
Emotional state of mother during pregnancy					
Mother's diet during pregnancy					

Birth mother's illnesses during pregnancy (circle):

Hypertension	Gestational Diabetes	Pre-eclampsia	Eclampsia
Bleeding	Excessive Vomiting / Nausea	Anemia	Placenta previa
Trauma	Maternal rubella	Maternal toxoplasmosis	Cold / Flu

Other: _____

Substances used during pregnancy by birth mother (circle):
Tobacco Alcohol Caffeine Recreational drugs
Prescription Mediations Herbal Preparations Over the counter drugs
Other: _____

Interventions used during the pregnancy (circle): Ultrasound Amniocentesis

Term length of pregnancy (circle):
Pre-term (37 weeks or less) Full term (38-42 weeks) Post term (42 weeks)

Type of labour (circle) : Spontaneous Induced

Type of delivery (circle): Vaginal C-section

Where did the birth take place? Hospital Home Other

Interventions used during the delivery (circle) Epidural Forceps Suction

Complications with the delivery (circle):
Difficult delivery Long 2nd stage of labour Breech delivery Shoulder dystocia Other_____

Interventions administered at birth (circle): Vitamin K Eye drops

At birth: Weight_____ Length_____ APGAR Scores_____

Complications after delivery (circle):
Jaundice Rash Colic Seizures
Respiratory distress Birth defects Bleeding Fever
Hip displacement Scoliosis Injuries during birth Infections
Other: _____

Breast Fed: Yes No How long: _____

Bottle Fed: Yes No How Long: _____

What type of formula was used? (milk, soy, other)_____ Combined with breast milk? _____

Were there any reactions to the formula? _____

Introduction of Solid Foods: When? _____

First Foods in order of introduction (specify if bottled or fresh)
_____

_____

Were there any reactions to the foods listed above? (colic, constipation, congestion etc)

_____

DEVELOPMENTAL MILESTONES

At what age did your child:

Crawl _____ Walk _____ Talk _____ Toilet train _____

LIFESTYLE PATTERNS

What time does your child go to bed?_____ Wake ?_____
Does your child take naps?_____ When?_____ How long? _____
Does your child have trouble falling asleep? _____
Does your child sleep through the night?_____
What position does your child sleep in?_____
Does your child wake up looking / acting refreshed?_____
Does your child have any recurring dreams or nightmares? _____
_____
What is your child's energy like during the day?_____
Is your child currently in school, daycare, at home?_____
How would you describe your child's behaviour in school / daycare _____
_____
Does this differ greatly from behaviour at home?_____

Does your child watch TV?	Yes	No	How often?_____
Does your child play video games?	Yes	No	How often?_____
Does your child play on the internet?	Yes	No	How often?_____
Does your child have family time?	Yes	No	How often?_____
Does your child get exercise?	Yes	No	How often?_____

What does your child like to do for exercise?_____
What are your child's hobbies / interests? _____

Please write a short description of your child as he/she is currently. Include strengths, weaknesses, fears and major personality traits:

_____

_____

_____

_____

Is there anything that you feel is important that has not been covered?_____

_____

_____

Thank you for taking the time to fill out these forms.