

PEDIATRIC HEALTH INTAKE

Dear Patient,

Thank you for choosing me as your naturopathic physician for naturopathic medical care. I realize that this is a fairly lengthy questionnaire that you are required to fill out for your child. You deserve to know why it is important. Not only does it provide me with vital information about your child's medical history and concerns, but also it gives me a sense of your family, habits, and your child's personality. I feel this is essential in treatment so we can work together to reach optimal health for your child. So, please answer the questions to the best of your ability. During our appointment, we shall talk together, discussing your child's health concerns and reviewing the questionnaire; combined with a physical examination and laboratory tests, this information will help me provide you with the best possible personal naturopathic medical care.

The information in this questionnaire will be kept confidential. Thank you for your cooperation.

Bibliographic Data

Child's Name _____ Date of Birth _____
 Place of Birth _____ Age _____ Sex _____
 Parent/Guardian _____ Race/Ethnic Origin _____
 Address _____ Phone Number _____
 _____ Alternate Phone Number _____
 Care Card Number _____ Referred by Whom _____

Contacts

1. Contact _____ Relation to Child _____
 Address _____ Phone Number _____
 2. Contact _____ Relation to Child _____
 Address _____ Phone Number _____

Other Healthcare Providers

1. Name _____ 2. Name _____
 Address _____ Address _____
 Phone Number _____ Phone Number _____

Present Health Concerns (in order of importance, duration of complaint, past treatment)

1. _____
2. _____
3. _____
4. _____

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Is the child currently taking any medications or supplements? _____

If so, please specify _____

Prenatal Health

Health of parents at conception:

Mother Poor Fair Good Excellent Unknown

Father Poor Fair Good Excellent Unknown

Health of mother during pregnancy: Poor Fair Good Excellent Unknown

during pregnancy:

Diet of mother during pregnancy: Poor Fair Good Excellent Unknown

during pregnancy:

Age of Mother at child's birth: _____

Did the mother seek prenatal care: _____

Did the mother experience any of the following problems during pregnancy?

- Bleeding High Blood Pressure Nausea
 Diabetes Thyroid Problems Vomiting
 Other _____ Physical Trauma Emotional Trauma

Did the mother use any of the following during pregnancy?

- Supplements (e.g., vitamins) Alcohol Recreational Drugs
 Prescription medications Tobacco Other _____

Birth History

Term length: _____ weeks Length of labour: _____ hours Weight of baby at birth: _____

Any complications? _____ No. of pregnancies? _____

Birth: Vaginal C-section Induced Forceps Anesthesia

Did the child experience any of the following at or shortly after birth?

- Jaundice Seizures Birth defects
 Rashes Birth injuries Other _____

Childhood History

Accidents or Injuries _____

Serious or Chronic Illnesses _____

Hospitalizations _____

Operations _____

Immunizations _____

Illnesses in the Family

Check in **Child** column if any one of the following has happened to your child. Check the **Blood Relative** column if any of the following have happened to a blood relative and state the relationship (parent, sibling, etc.):

Table with 4 columns: Child, Blood Relative, Child, Blood Relative. Rows list various conditions like Diabetes, Asthma, Allergies, etc.

Other _____

Genetic/inherited disease _____

Diet

Breastfed (if yes, for how long) _____

Formula (Specify soy, milk, other) _____

What foods, if any were given prior to 6 months?

4-8 weeks _____

8-12 weeks _____

12-16 weeks _____

16-20 weeks _____

20-24 weeks _____

6 to 12 months _____

Did your child ever experience colic? _____ If yes, how severe and for how long? _____

Describe your child's typical day's diet.

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Development

At what age did your child first:

Sit up _____ Crawl _____ Walk _____ Talk _____

Did your child have teething difficulties? _____

Describe your child's sleep pattern (e.g., bed times, wake times, any trouble falling asleep, naps, nightmares, dreams).

Describe your child's behaviour and performance at school. _____

Describe your child's personality. _____

Has there been any change in your child's personality? _____

Environment

Is/Was your child in daycare? _____

What are your child's favourite activities? _____

What are your child's favourite toys? _____

Does your child exercise regularly, how often? _____

How much television does your child watch, hours per day/per week? _____

Does your child have any siblings? _____

If so, what birth order is your child (e.g., eldest)? _____

Does your child read books outside of school? Daily _____ Weekly _____ Monthly _____

Does your child have any extracurricular activities outside of school? _____

Does anyone in the child's household smoke? _____

How would you describe the emotional climate of the child's home? _____

Do you have any pets? _____

Is there anything else that you would like to add? _____

Does your child have any sensitivities to light, heat, cold, dark, or odors? _____

GENERAL (Please check if any of the following symptoms are currently a problem or are a recurring problem, if in the past, indicate with a P)

Current Weight: _____

- | | | |
|--|---|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Chills | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Sweat Easily | <input type="checkbox"/> Tremors | <input type="checkbox"/> Cravings |
| <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Poor balance | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Sudden energy drop (time of day?) | <input type="checkbox"/> Strong thirst (hot or cold drinks) | <input type="checkbox"/> Peculiar tastes or smells |

SKIN AND HAIR

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Change in hair or skin texture | <input type="checkbox"/> Any other hair or skin problems _____ | |

GASTROINTESTINAL

- | | | |
|---|---|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Indigestions | <input type="checkbox"/> Black stools |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Belching | <input type="checkbox"/> Blood in stools |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas | <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Any other stomach problems _____ |
| <input type="checkbox"/> Abdominal pain or cramps | <input type="checkbox"/> Chronic laxative use | |

MUSCULOSKELETAL

- | | | |
|--|---|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Foot/Ankle pain |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Hand/Wrist pain | <input type="checkbox"/> Swelling of joints |
| <input type="checkbox"/> Joint nodules | <input type="checkbox"/> Any other joint or bone problems _____ | |

RESPIRATORY

- | | | |
|--|---|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Pain with deep breath |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Difficulty breathing lying down | <input type="checkbox"/> Production of phlegm (colour?) | <input type="checkbox"/> Any other lung problems _____ |

HEAD/EYES, EARS, NOSE, AND THROAT

- | | | |
|--|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Eye pain |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Colour blindness |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor healing | <input type="checkbox"/> Spots in front of eyes |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Recurrent sore throats |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Sores on lips or tongue |
| <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Jaw clicks | <input type="checkbox"/> Headaches (where/when) |
| <input type="checkbox"/> Any other head or neck problems _____ | | |

CARDIOVASCULAR

- | | | |
|---|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Swelling of hands | <input type="checkbox"/> Swelling of feet |
| <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Any other heart or blood vessel problems _____ | | |

GENITO-URINARY

- | | | |
|---|--|---|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Inability to hold urine | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Increased frequency in the day | <input type="checkbox"/> Increased frequency in the night | <input type="checkbox"/> Frequent infections: (bladder/kidney |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Any other genito-urinary problems _____ | |

NEUROPSYCHOLOGICAL

- | | | |
|---|---|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Blood in stools |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Depression | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Quick temper/irritable | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Easily susceptible to stress |
| <input type="checkbox"/> Has your child ever been treated for emotional problems? | <input type="checkbox"/> Has your child ever considered or attempted suicide? | <input type="checkbox"/> Any other neurological or psychological problems _____ |

COMMENTS

Please indicate any other problems you would like to discuss.
