HEALTHY FOUNDATIONS
NATUROPATHIC CLINIC

Pediatric Intake Form

Dear Parent/Guardian;

Thank you for taking the time to fill out the following form regarding your child. The information you are providing is extremely valuable, as it allows us to offer the best treatment options possible. We ask that you kindly return this form prior to the initial appointment, either via fax (705-243-5166), mail, or dropping it off at the clinic. If this is not possible, please bring the form to the appointment. Please know that the information gathered on this form will be treated in a strictly confidential manner.

What to expect at the first visit:

- The first visit will be approximately 1 hour and 15 minutes long. During the first visit, the Naturopathic Doctor will review and discuss your child's patient intake form in more detail, answer any questions you and your child may have, possibly perform a partial physical exam and then discuss treatment options.
- Some additional testing may be suggested during this visit (these tests are not included in the cost of the initial visit).

What to bring to your first visit:

- All the medications and supplements your child is currently taking
- Any recent blood work or test results

Please feel free to call us at 705-243-5163 if you have any questions or concerns.
We look forward to meeting you and your child!

Yours truly,

Dana Marshall, ND and Susan Joyce, ND
Healthy Foundations Naturopathic Clinic

"Providing our patients with the foundations for good health"

HEALTHY FOUNDATIONS - NATUROPATHIC CLINIC
291 Charlotte Street • Unit A • Peterborough, Ontario • K9J 2V6
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CONTACT INFORMATION

Today's Date: _____

Name of Child: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Age: _____

Name of Parent / Guardian: _____

Phone:

Home _____ ☐ Preferred Contact Number

Cell _____ ☐ Preferred Contact Number

Work _____ ☐ Preferred Contact Number

Email Address: _____

I would like to receive communication from Healthy Foundations Naturopathic Clinic (i.e. E-newsletters, etc.) ☐ Yes ☐ No

Mailing Address: _____

_____

_____

Emergency Contact:

Name _____

Relation _____

Phone Number _____

How did you hear about our clinic ?

☐ Website ☐ Yellow Pages ☐ Referral (please see below)

☐ Radio ☐ Newspaper ☐ Other: _____

If referred, can you please provide by whom: _____

Do you have health insurance coverage for Naturopathic Medicine ? ☐ YES ☐ NO

CLINIC PARKING

Please note that there is first come, first serve parking available on the lot facing Stewart Street. There is metered parking on Charlotte Street (with 15 mins. free parking), one hour free parking on Stewart, south of Charlotte, and all day free parking on Stewart, north of Charlotte.

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HEALTH CONCERNS

What are the main health concerns of your child (please list in order of importance):

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

MEDICAL HISTORY

Pregnancy Details

Length of pregnancy ? _____ weeks At child's birth: Age of Mother _____

How much weight did the mother gain during the pregnancy ? _____ lbs Age of Father _____

Did the child's mother travel at all during the pregnancy ? ☐ Y ☐ N

If yes: Where ? _____

Please list all medications and supplements taken by the mother during pregnancy:

MEDICATION	SUPPLEMENT
1.	1.
2.	2.
3.	3.
4.	4.

Please list any illnesses / complications the mother experienced during pregnancy (i.e. Gestational diabetes, morning sickness, toxemia, etc.)

ILLNESS / COMPLICATION	TREATMENT

Was the child's mother exposed to cigarette smoke during pregnancy ? ☐ Y ☐ N

DURING pregnancy, did the child's MOTHER use:

Alcohol ? ☐ Y ☐ N If yes, how much ? _____ drinks / week

Recreational Drugs ? ☐ Y ☐ N If yes, how much ? _____ usages / week

PRIOR TO pregnancy, did the child's FATHER use:

Alcohol ? ☐ Y ☐ N If yes, how much ? _____ drinks / week

Cigarettes ? ☐ Y ☐ N If yes, how much ? _____ cigarettes / day

Recreational Drugs ? ☐ Y ☐ N If yes, how much ? _____ usages / week

Mother's work environment **DURING** pregnancy: ☐ Stressful ☐ Long hours ☐ Exposure to toxins

Father's work environment **PRIOR TO** pregnancy: ☐ Stressful ☐ Long hours ☐ Exposure to toxins

MEDICAL HISTORY (continued)

Delivery Process:

Please check all that apply to the delivery process of your child:

☐ Induction ☐ Midwife ☐ Doula ☐ Medical Doctor
☐ Epidural ☐ Vacuum ☐ Forceps ☐ Vaginal birth
☐ C-Section ☐ Medications ☐ Other: _____

Were there any complications with the delivery (please explain):

_____
_____
_____
_____

The child's mother recovered post-delivery in: _____ **days** / **weeks** (please circle)

Newborn Stage:

The child's weight at birth was: _____ **lbs** _____ **ounces**

Please check any of the following that were concerning with your child as a newborn:

☐ Feeding ☐ Rashes ☐ Jaundice ☐ Other: _____

Growing Years Stage:

Was your child breastfed ? ☐ Y ☐ N If YES, for what duration ? _____ months

How long after birth was formula introduced ? _____ months BRAND: _____

How long after birth was food introduced ? _____ months

Please list order of initial food introductions (approx.) and any reactions to these introductions:

FOOD INTRODUCTION	REACTION(s)
1.	
2.	
3.	
4.	
5.	

In general, you would describe your child's eating habits as:

☐ Very good ☐ Satisfactory ☐ Poor ☐ Significantly challenging

Please briefly describe your child's eating habits:

_____
_____
_____

Please list any allergies / sensitivities (food / medication / environmental) your child exhibits:

_____ _____
_____ _____
_____ _____

How many bowel movements does your child have per day ? _____

MEDICAL HISTORY (continued)

Growing Years Stage (continued):

Please describe your child's sleeping patterns:

_____

_____

_____

How old (in months) was your child when:

Got first tooth _____ Started to: Crawl _____ Walk _____ Talk _____

Please describe your child's health in his / her first year:

_____

_____

_____

Vaccination Schedule: ☐ Regular ☐ Alternative Reactions: _____

How often does your child get: **Colds** ☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently

Ear Infections ☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently

Please list any past injuries / hospitalizations (i.e. Car accidents, surgeries, etc.) your child has experienced

TYPE OF INJURY / SURGERY	HOSPITALIZATION	HOW DID IT HAPPEN ?	AGE
	☐ Y ☐ N		
	☐ Y ☐ N		
	☐ Y ☐ N		
	☐ Y ☐ N		

Please fill out the following in regards to **CURRENT SUPPLEMENTS** your child is taking

SUPPLEMENT	DAILY DOSE	FOR HOW LONG	REASON
1.			
2.			
3.			
4.			

Please fill out the following in regards to **CURRENT MEDICATIONS** your child is taking

MEDICATION	DAILY DOSE	FOR HOW LONG	REASON
1.			
2.			
3.			
4.			

What is the general mood of your child ? _____

Please list any life changing events your child has experienced (i.e. birth of a sibling, divorce, death of a loved one, etc.):

_____

_____

_____

_____

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FAMILY MEDICAL HISTORY

Please indicate whether any of your child's family members have, or have had, the following:

TYPE OF CONDITION	Mother	Father	Gr. Parent	Sibling	Aunt/Uncle
Diabetes	☐	☐	☐	☐	☐
Autoimmune Conditions (i.e. Lupus)	☐	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Inflammatory Bowel Disease	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

LIFESTYLE

On average, your child spends _____ hours per day watching TV or playing computer / video games

How does your child interact with his / her peers ? (please explain)

_____

_____

_____

Is your child involved in any extra curricular activities ? ☐ Y ☐ N

If yes: How many hours per week ? _____

How is your child doing academically ?

☐ Above average ☐ Average ☐ Below average

Does your child enjoy school ? ☐ Y ☐ N

How old is your place of residence (approx.) ? _____ years old

Have there been any recent renovations ? ☐ Y ☐ N

Do you live in a basement ? ☐ Y ☐ N

Are there any pets in the house ? ☐ Y ☐ N Please list: _____

Are there any major stressors currently in the household (i.e. Someone sick, conflict, etc.) ? ☐ Y ☐ N

If yes, please list / explain : _____

_____

_____

_____

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CHILD'S MEDICAL DETAILS

Please note any conditions your child has had in the **PAST (P)** or is **CURRENTLY (C)** experiencing:

ENDOCRINE

- ☐ P ☐ C LOW BLOOD SUGAR
- ☐ P ☐ C SUDDEN WEIGHT CHANGE
- ☐ P ☐ C POOR CONCENTRATION
- ☐ P ☐ C EXCESSIVE THIRST
- ☐ P ☐ C EXCESSIVE HUNGER

HEAD, EARS, EYES, NOSE, MOUTH

- ☐ P ☐ C HEADACHES
- ☐ P ☐ C DIZZINESS
- ☐ P ☐ C IMPAIRED HEARING
- ☐ P ☐ C EAR INFECTIONS
- ☐ P ☐ C GLASSES / CONTACT LENSES
- ☐ P ☐ C LIGHT SENSITIVITY
- ☐ P ☐ C NOSEBLEEDS
- ☐ P ☐ C SINUS PROBLEMS
- ☐ P ☐ C HAYFEVER
- ☐ P ☐ C GUM PROBLEMS
- ☐ P ☐ C FREQUENT SORE THROAT
- ☐ P ☐ C MOUTH SORES
- ☐ P ☐ C JAW PAIN OR CLICKING
- ☐ P ☐ C SWOLLEN NECK GLANDS
- ☐ P ☐ C DRY TONGUE / MOUTH

SKIN

- ☐ P ☐ C ECZEMA
- ☐ P ☐ C PSORIASIS
- ☐ P ☐ C HIVES / RASHES
- ☐ P ☐ C ITCHING
- ☐ P ☐ C DRYNESS
- ☐ P ☐ C ACNE

VASCULAR / LYMPHATIC

- ☐ P ☐ C EASY BRUISING / BLEEDING
- ☐ P ☐ C COLD HANDS / FEET
- ☐ P ☐ C LYMPH NODE SWELLING

MUSCLE AND JOINT

- ☐ P ☐ C MUSCLE CRAMPS / SPASMS
- ☐ P ☐ C MUSCLE WEAKNESS
- ☐ P ☐ C JOINT SWELLING

GASTROINTESTINAL

- ☐ P ☐ C CONSTIPATION
- ☐ P ☐ C DIARRHEA
- ☐ P ☐ C NAUSEA / VOMITING
- ☐ P ☐ C EXCESSIVE GAS / BLOATING
- ☐ P ☐ C BLOOD IN STOOL
- ☐ P ☐ C ABDOMINAL PAIN / BLOATING

URINARY

- ☐ P ☐ C FREQUENT URINARY TRACT INFECT.
- ☐ P ☐ C FREQUENCY AT NIGHT
- ☐ P ☐ C BEDWETTING
- ☐ P ☐ C INABILITY TO HOLD URINE
- ☐ P ☐ C STRONG SMELLING URINE

RESPIRATORY

- ☐ P ☐ C COUGH
- ☐ P ☐ C SHORTNESS OF BREATH
- ☐ P ☐ C ASTHMA
- ☐ P ☐ C BRONCHITIS
- ☐ P ☐ C PNEUMONIA
- ☐ P ☐ C PHLEGM

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