



Pediatric Intake Form

Name: _____

Address: _____ City: _____

Postal Code: _____ Phone: _____

Age: _____ Date of Birth: _____ Sex: M F

Height: _____ Weight: _____ Grade Level: _____

Nationality: _____ Blood Type: _____

Parents/Legal Guardian: _____

Email Address: _____

Health Insurance Provider & Naturopathic Amount _____

How did you hear about this clinic: _____

Emergency Contact

Name and relation to child: _____

Address: _____

Phone: (home) _____ (work) _____

Who does the child currently live with? _____

Other Health Care Providers

Provider#1 name: _____

Designation (e.g., pediatrician, family physician, etc.): _____

Address: _____ Phone: _____

Provider#2 name: _____

Designation: _____

Address: _____ Phone: _____

What was the reason for your child's last visit to a health care provider? When was the last visit? _____

Health Concerns

1. Primary health concern: _____

At what age did this condition/illness begin? _____

Has this condition occurred before? _____

Does anything make the condition better or worse? _____

Prior treatments if any and outcomes of the treatments _____

Other health concerns:

2. _____

3. _____

4. _____

5. _____



Medical History

How would you describe your child's general state of health?

Excellent Good Fair Poor

Has your child ever experienced any of the following illnesses?

- | | | |
|--|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Mumps | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Small pox |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Polio | <input type="checkbox"/> Typhoid |
| <input type="checkbox"/> Mono | <input type="checkbox"/> Rubeola | <input type="checkbox"/> Other: _____ |

Does the child have any allergies to drugs, foods, environment, animals or other?

Please list any previous hospitalizations or surgeries? _____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.) _____

Please indicate the immunizations your child has had and 'when':

Immunization	Date		Date
DPT (Diphtheria, Pertussis, Tetanus)	_____	Polio	_____
MMR (Measles, Mumps, Rubella)	_____	TB	_____
Haemophilus influenza B	_____	Flu	_____
Smallpox	_____	Chickenpox	_____
Pneumovaccine	_____		
Hepatitis A	_____	Hepatitis B	_____

Did your child have any reactions or complications with the above indicated vaccines?

Family History

Relation	Living (Age)	Any health concerns	Died (age)	Cause of Death
Mother				
Father				
Brother(s)				
Sister(s)				
Maternal grandmother				
Maternal grandfather				
Paternal grandmother				
Paternal grandfather				



Have any blood related family members ever suffered from:

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Genetic disorders |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sickle cells |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid condition | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Other: _____ | | |

Prenatal Health and History

What was the health of the parents at conception?

Mother:	Excellent	Good	Fair	Poor	Unknown
Father:	Excellent	Good	Fair	Poor	Unknown

What was the mother's age at the child's birth? _____

How was the mother's health during the pregnancy?

Excellent Good Fair Poor Unknown

How was the mother's diet during the pregnancy?

Excellent Good Fair Poor Unknown

What was the mother's level and type of exercise during pregnancy?

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Physical trauma | <input type="checkbox"/> Emotional trauma | |
| <input type="checkbox"/> Other: _____ | | |

Did the mother use any of the following during the pregnancy?

- | | | |
|--|----------------------------------|--|
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Recreational drugs: _____ |
| <input type="checkbox"/> Prescription medications: _____ | | |
| <input type="checkbox"/> Over-the-counter medications: _____ | | |
| <input type="checkbox"/> Supplements: _____ | | |
| <input type="checkbox"/> Other: _____ | | |

Was the mother exposed to any of the following during the pregnancy?

- | |
|--|
| <input type="checkbox"/> Diseases: _____ |
| <input type="checkbox"/> Toxins: _____ |
| <input type="checkbox"/> Other: _____ |

What was the mother's mental status during the pregnancy?

Were any of the following interventions used during pregnancy?

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Amniocentesis | <input type="checkbox"/> Chorionic villi sampling | <input type="checkbox"/> Triple Screen |
| <input type="checkbox"/> Maternal serum screening <input type="checkbox"/> other: _____ | | | |



Birth History:

Number of pregnancies: _____ Number of miscarriages: _____

Term length with this child: Full Premature: _____ wks

Late: _____ wks

Length of labour: _____ Weight at birth: _____ Height at birth: _____

Head Circumference: _____

Apgar score: 1 Minute _____ 2 Minutes _____ 5 Minutes _____

Any complications during the delivery? _____

Location of birth: Hospital Home Birthing Center Other: _____

Was the birth: Vaginal C-section Induced Forceps

Anesthesia/ Epidural used Episiotomy

Mother's emotional status at the time of birth? _____

Mother's emotional status post-partum?

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

Jaundice Rashes Seizures

Respiratory distress Infections Colic Anemia

Birth injuries/defects: _____

Other: _____

In general, how was your child's health in the first year?

Poor Fair Good Excellent Unknown

Diet

Breast fed. How long? _____

Formula (type): _____

Other: _____

Did your infant experience any difficulties with the formula or breast milk? _____

When was solid food introduced? _____

What foods were first introduced? Please indicate the age that the foods were introduced and if there were any reactions to the foods.

Describe a typical day's diet for your child? (Approximate quantities)

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

Please describe your child's eating habits (ie. picky eater, large appetite etc.).



Review of Systems

Please indicate any of the following conditions your child now experiences or has in the past:

- | | | |
|---|--|---|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Asthma or Allergies | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Frequent Colds/Flues | <input type="checkbox"/> Strep throat |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Visual problems | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Recurring Fevers |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Back/neck Pains | <input type="checkbox"/> Dental Cavities |
| <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Hernias | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Undescended testes |

Bowel Movement frequency _____

Bowel Movement appearance _____

Has your child ever had any significant physical or emotional traumas? _____

Development

Please indicate at what age your child began the following:

Teething _____

Sitting _____

Crawling _____

Walking _____

Talking _____

Potty training _____

Were there problems associated with any of the above mentioned stages?

Sleep

What time does your child usually go to bed? _____

What time does your child usually wake in the morning? _____

Does your child nap during the day? Yes No What time(s): _____

Does your child have nightmares? Yes No How often? _____

Does your child have any problems associated with sleeping (e.g., trouble falling asleep, trouble waking up, etc.)? _____

Social

Is your child in: school daycare home care other? _____

How would you describe your child's temperament?

Please circle 'y' for yes, or 'n' for no. Does your child:

- | | | | | | |
|------------------------|---|---|----------------------|---|---|
| Cry (frequency?) | Y | n | Have temper tantrums | y | n |
| Plays well with others | y | n | Have fantasy friends | y | n |
| Watch TV (frequency) | y | n | Aggressive | y | n |
| Shares | y | n | Independent | y | n |



How would you describe your child's behavior at home?

How would you describe your child's behavior and performance at school/daycare?

What are your child's interests?

What are your child's fears?

What are the child's favorite activities?

How much physical fitness does your child get?

What extracurricular activities/sports is the child involved in? (if any) How frequently does the child perform these activities?

How often does your child read (not for school), or How often does someone read to your child?

Daily Several times a week Weekly Less than weekly

Is the child exposed to?

Smokers? _____

Alcohol or drug abusers? _____

Physical or verbal abuse? _____

Un/safe neighborhood? _____

Toxins (aluminum, lead copper..) _____

Environment

Are there any pets in the home? Yes No what type and how many? _____

How is the child's home heated? _____

How would you rate the stress level of the child's home? (0-10) _____

Is there anything that you feel is important that you would like to add? _____



Acknowledgment and Consent to Treatment: *(Please initial applicable sections.)*

Naturopathic Medicine Clients:

Naturopaths are regulated in Ontario by the Board of Directors of Drugless Therapy – Naturopathy (*the Drugless Practitioners Act*). Naturopathic doctors provide primary and complementary health care by focusing on the rational use of natural therapies to support and stimulate healing processes. Naturopathic doctors use standard medical diagnostic tools (physical exam, case history, laboratory and Imaging studies, etc.) Therapies used in naturopathic practice are:

- | | | |
|------------------------------|---------------------------------|----------------|
| Botanical Medicine | Clinical Nutrition | Initial: _____ |
| Homeopathic Medicine | Lifestyle/Fitness Counseling | |
| Eastern Medicine/Acupuncture | Physical Therapeutic Procedures | |

Naturopathic & Fitness Clients:

A confidential record will be kept of health and fitness services provided to you and will not be released without your consent or unless directed by law. You may look at your file at any time and can request a copy by paying a fee.

Initial: _____

I voluntarily consent to the diagnostic, therapeutic and or training procedures mentioned above. I understand that there are health risks involved with Naturopathic Medicine and/or Fitness Training services and I hereby release The Roberts Centre of Integrative Medicine Inc. (its employees and owners) from any claims, demands and causes of action arising from my voluntary participation in these services.

Initial: _____

I understand that failure to follow naturopathic or fitness prescriptions could undermine the expected results. Naturopathic Doctors reserve the right to determine which cases fall outside his scope of practice, in which event an appropriate referral will be made.

Initial: _____

All fees, for services and supplements are payable at the time of the appointment. There is a fee for completing insurance forms, letter writing, and telephone consultations of greater than 5 minutes. **Please give 24 hours notice for appointment cancellations.**

Initial: _____

I have read, understood, and acknowledge the above statements. I intend this consent form to cover the entire course of treatment/training. I am free to withdraw my consent and or terminate treatment/training at any time.

Date: _____

Patient Name (print): _____

Signature of Patient (or Guardian): _____

Naturopath: _____