



Braidwood Naturopathic Clinic

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Pediatric Intake Form (Birth – 5 Years)

Patient's name: _____ Date of first visit: _____

Age: ____ Date of Birth: ____/____/____ Gender: female male

Mother's name: _____ Father's name: _____

Address: _____ City: _____ Province: _____ Postal: _____

Phone # (home): (____) _____ Parents # (work): (____) _____

Parents e-mail address: _____

How did you hear about our clinic? _____

Name of Dr.'s Office/Hospital/Clinic where your child's health records are kept:

Reason for referral or presenting problems: _____

MEDICATIONS	Now	Past		Now	Past
Aspirin	____	____	Antibiotics	____	____
Tylenol	____	____	Anti-histamine	____	____
Decongestant	____	____	Other	____	____
Ibuprofen	____	____	Allergies to medicines	_____	_____

MEDICAL HISTORY

____ Chicken pox ____ Scarlet fever ____ Tonsillitis, approx. no. _____

____ Measles ____ Pneumonia ____ Ear infections, no. _____

____ Mumps ____ Frequent colds ____ other (please list) _____

____ Rubella ____ Rheumatic fever

Has your child had any of the following tests? When Where Results

Electroencephalogram _____

Psychological evaluation _____

Hearing _____

Speech/Language _____

Injuries/Surgeries/Hospitalizations (please list): _____

IMMUNIZATIONS

____ Measles ____ Polio ____ MMR ____ Smallpox ____ Diphtheria

____ Mumps ____ DPT ____ Tetanus ____ Influenza ____ Other

Any adverse reactions? Y N If yes, please explain _____

FAMILY HISTORY

____ Heart disease ____ Diabetes ____ Birth defects ____ Cancer

____ Hypertension ____ Arthritis ____ Mental illness ____ Allergies

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications? _____

Mother's age at child's birth? _____

Mother's health during pregnancy?

- Bleeding Physical or emotional trauma
- Nausea Cigarettes, alcohol, drug consumption
- Illnesses Medications
- Hypertension Thyroid problems Diabetes

BIRTH HISTORY

Term: Full _____ Premature _____ Late _____ Weight at birth _____

Length of labor _____ Complications? _____

Did your child have any of the following problems shortly after birth?

- Birth defects Birth injuries Blue baby
- Cerebral palsy Seizures Jaundice
- Colic Fever Rashes

Other (explain) _____

Child's sleep patterns (first year) _____

Food intolerances (if any) _____

Feeding: Breast fed? _____ how long? _____ Formula? _____ milk / soy

Age began solids _____ Which foods? _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS (mark **Y** if current, **P** significant past symptom)

- Hives Burning of urine Bloody urine
- Eczema Frequent urination Cries easily
- Bleeding gums Heart murmur Nervous
- Nose bleeds Vomiting spells Sleep problems
- Acne Anemia Night sweats
- High fevers Stomach aches Sensitive to light
- Chronic rash Jaundice Body/breath odor
- Hearing loss Easy bruising Motion/car sickness
- Diarrhea Flat feet No appetite
- Sore throats Constipation Nightmares
- Headaches Gas Canker sores
- Frequent colds Bleeding tendency Unusual fears
- Wheezing Joint pains Excessive fatigue
- Cough Dizzy spells Hair loss

DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Thank you. I look forward to helping your child in any way I can.