Dr. Zar
Naturopathic Doctor

Naturopathic Pediatric Intake Form (Child: 0-12)

Personal Information

Child's Name:_____

Date of Birth:_____ Age: _____ Sex:_____

Parent/Guardian name: _____

Occupation: _____

Address:_____

Email address: _____

Telephone: Home: _____ Cell: _____

Is your infant under the care of another healthcare provider? If so, who?

Name: _____ Name: _____

Address: _____ Address: _____

Number: _____ Number: _____

How did you hear about this clinic?

_____

Chief Concerns

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

Please list past hospitalizations/surgeries/accidents/traumas:

_____

Has your infant had any illnesses that you feel they haven't recovered from? If yes please explain:

_____

Medication Dosage Start Date Reason

Has any aspect of your infant's health recently changed or become worse?

_____

Please list all medications (including prescription, over-the-counter, and **natural products**) you are **currently** giving your infant along with the dose and the reason for taking them:

Has your infant been prescribed antibiotics? _____ Reason: _____

Allergies to medicines: _____

Has your infant been vaccinated? ____ Do you have any questions about vaccinations? _____

Please indicate what immunizations your child has had: ¨ DPT (diphtheria, pertussis, tetanus)	¨ Haemophilus influenza B	¨ Hepatitis B
¨ Tetanus booster; when? _____	¨ "Flu"	¨ Hepatitis A
¨ MMR (measles, mumps, rubella)	¨ Polio	¨ Smallpox

Please indicate if any caused adverse reactions:

_____

_____

What screening tests has your child had (blood, hearing, vision, etc.)?

_____

_____

Have you breastfed? _____ For how long? _____ Formula? _____

Are there any foods that seem to irritate your infant when passed through breastmilk?

_____

Have you introduced solid foods? _____

Is there anything that your infant doesn't tolerate? _____

Please describe your infant's personality:

_____

What is the emotional climate of your home:

_____

Are there any other children in the home? _____ Pets? _____

Does anyone in the home smoke? _____

Do you have any concerns about your child's eating/sleeping/bowel habits?

_____

Prenatal Health

What was the health of the parents at conception?

Mother: Poor Fair Good Excellent Unknown

Father: Poor Fair Good Excellent Unknown

What was the health of the mother during the pregnancy?

Poor Fair Good Excellent Unknown

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

How was the mother's diet during pregnancy?

Poor Fair Good Excellent Unknown

Did the mother receive prenatal medical care? Y N Unknown

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

☐ Bleeding	☐ High blood pressure	☐ Nausea	☐ Vomiting
☐ Diabetes	☐ Thyroid problems	☐ Physical or emotional trauma	

Birth History

Term length: ¨ Full ¨ Premature: _____ wks ¨ Late: _____ wks

Length of labour: _____ Weight at birth _____

Any complications?

_____

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

Jaundice ___ Rashes ___ Seizures ___ Birth injuries ___ Birth defects ___

Other _____

Was the birth vaginal or via c-section? _____

Were there any birth trauma/complications? _____

Is there anything that hasn't been covered in this form that you'd like to add?

_____

Diet:

What foods were introduced before 6 months? (Please list approximate month as well.)

_____

_____

_____

6–12 months?

_____

_____

_____

_____

_____

_____

Did your child ever experience colic? Y N How severe? mild moderate severe

Does your child have any food allergies or intolerances? Please list.

_____

_____

_____

_____

_____

_____

Describe a typical day's diet:

Breakfast

_____

_____

Lunch

_____

_____

Dinner

_____

_____

Snacks

_____

_____

Beverages (and total quantity)

_____

Health and Development:

How was your child's health in the first year?
Poor Fair Good Excellent Unknown

At what age did your child first:
Sit up _____ Crawl _____ Walk _____Talk_____

Describe your child's sleep pattern:

_____

_____

_____

_____

How would you describe your child's temperament?
_____

How would you describe your child's behaviour and performance at school?
_____

_____

_____

Family History:

Indicate if a close relative (parent, sibling) has had any of the following Who?	Who?
Allergies	Diabetes
Asthma	Kidney disease
Birth defects	Other
Juvenile arthritis	

Do either of the parents have a chronic illness? Y N Please describe:
_____

Environment:

Is the child in:

School daycare home care other

What are your child's favorite activities?

_____

_____

_____

Does the child exercise regularly? Y N **How much, how often?**

_____

_____

How much television does your child watch? _____ hrs a day/week

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

Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)? Please describe.

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

The information I've provided is true and complete to the best of my ability.

Parent's Signature: _____

Date:_____