NATUROPATHIC PEDIATRIC INTAKE FORM

This information is strictly confidential and is only used in accordance with our privacy policy.

CONTACT INFORMATION

Child's Name: _____ Date: _____

Address: _____

Postal Code: _____ Landline. #: _____

Mother's Name: _____ Father's Name: _____

Mother's Contact #: _____ Father's Contact #: _____

Email Address: _____

PATIENT INFORMATION

Child's Date Of Birth: _____ Age: _____ Grade:_____ Gender:☐ M ☐ F ☐ O

Please list your child's main health concerns in order of importance to you.

1. _____
2. _____
3. _____

Please list your child's present health care provider with their designation (ie. Pediatrician).

_____

Does your child have any known contagious diseases at this time (please specify)?

_____

CHILD'S HEALTH HISTORY– Please check those that your child has experienced

Condition	Now	Past	Never	Condition	Now	Past	Never
Allergies	☐	☐	☐	Fatigue	☐	☐	☐
Anemia	☐	☐	☐	Headaches	☐	☐	☐
Asthma	☐	☐	☐	Heart murmur	☐	☐	☐
Bedwetting	☐	☐	☐	High fever	☐	☐	☐
Birth defect	☐	☐	☐	Hyperactivity	☐	☐	☐
Colic	☐	☐	☐	Insomnia	☐	☐	☐
Cough	☐	☐	☐	Jaundice	☐	☐	☐

Condition	Now	Past	Never	Condition	Now	Past	Never
Croup	☐	☐	☐	Learning problems	☐	☐	☐
Depression	☐	☐	☐	Moodiness	☐	☐	☐
Diarrhea	☐	☐	☐	Stuffy nose	☐	☐	☐
Dry skin	☐	☐	☐	Thrush	☐	☐	☐
Earache	☐	☐	☐	Vomiting	☐	☐	☐
Eczema	☐	☐	☐				

CHILDHOOD ILLNESSES – Please check those that your child has experienced

☐ Chicken pox	☐ Scarlet fever	☐ Mononucleosis
☐ Measles	☐ Rheumatic fever	☐ Ear infection
☐ Mumps	☐ Strep throat	☐ Tonsillitis
☐ Rubella	☐ Pneumonia	☐ Whooping cough

IMMUNIZATION HISTORY - Please list what, when, and any reaction

Vaccine	Yes / No	Reaction	Vaccine	Yes / No	Reaction
MMR			Hepatitis B		
DPT			Influenza		
Hepatitis A			Polio		
Tetanus			Smallpox		
COVID (Type/Dates)					

CHILD'S BIRTH HISTORY AND EARLY LIFE

Term: ☐ Full ☐ Premature _____ weeks ☐ Post Date: _____ weeks

Birthweight: _____ Length Of Labour: _____

Any complications? _____

Birth: ☐ Vaginal ☐ C-section ☐ Induced ☐ Forceps Or Suction ☐ Anesthesia

Mother's health during pregnancy and comments of labour and delivery: _____

_____

_____

Breast Fed: ☐ No ☐ Yes If yes, how long? _____

Formula Fed: ☐ No ☐ Yes If yes, how long and what type? _____

Age solid foods were introduced: _____

What foods and in what order? _____

_____

Does the child have any food allergies or aversions? _____

_____

What screening tests has your child had (ie. Hearing, vision): _____

_____

Describe the child's sleep patterns: _____

_____

Age Child Began: Sitting: _____ Crawling: _____ Walking: _____ Talking: _____

Does your child have any environmental allergies? _____

_____

SAMPLE DAILY DIET INCLUDING LIQUIDS

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you have any concerns about your child's diet? _____

_____

MEDICATIONS & SUPPLEMENTS - Please mark "C" for current use, and "P" for past use

Antibiotics	Fluoride
Aspirin	Tylenol
Other Vitamins and Supplements:	

Hospitalizations/surgeries/accidents/serious injuries and illnesses (please describe and date):

FAMILY HISTORY – Please identify family members who have had the following, if any:

Alcoholism	Diabetes	Hypoglycemia
Allergies	Eczema	Mental illness
Anemia	Epilepsy	Stroke
Arthritis	Heart disease	Other
Asthma	Hearing loss	

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

Radiant Health & Wellness ✷ 403.454.0255 ✷ www.radianthealth.ca ✷ info@radianthealth.ca