Regina Rehab & Family Medical Clinic

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Pediatric Intake Form, for children ages 0 – 12 years

Date:

Name:	Age:	Date of Birth:
Circle: Male or Female	Height:	Weight:
Names of Parents/ Guardians:		
Address:	City or town:	Province:
Postal code:	Home phone:	Parent's work phone:
Email address of parent:		
Name of person completing intake form:		
Relationship to patient:		

Medical History:

How did you find out about the naturopathic services at this clinic?
Last physician or practitioner seen? When?
Have you ever sought help from another Naturopathic practitioner?
What is the <u>main</u> reason for coming today?
How long has your child experienced this?
Is it getting better or worse over time?

List in order of importance other health concerns & length of time:

Concern	How long has this lasted?

Which of the following has your child experienced? And indicate "C" (current) or "P" (past) or "F" (frequent):

☐ Ear infections ☐ Eczema/ Skin problems ☐ Digestive problems ☐ Growing pains / Scoliosis

☐ Tonsilitis ☐ Allergies ☐ Colic ☐ Seizures

☐ Pneumonia ☐ Asthma ☐ Constipation/ Diarrhea ☐ Attention Problems – ADD/ADHD

☐ Sinus troubles ☐ Headaches ☐ Nausea/ Vomiting ☐ Bed Wetting

☐ Chicken pox ☐ Mumps ☐ Roseola ☐ Measles

☐ Bronchitis/ Upper Respiratory Infections ☐ Other (please specify):

Has your child ever been hospitalized (other than at birth)?

Date	Reason

Are you content with your child's present level of health? Please explain:

Is your child currently taking any medication? Yes No

Please list present and past medications, along with reason:

Medication	**When?**	**Reason?**

Approximate number of doses of antibiotics your child has taken:

Does your child take any herbal or vitamin supplementation? Yes No

If yes, please list:

Has your child received vaccinations? Yes No

If yes, which ones?

Were there any reactions observed? Please explain:

Prenatal History:

Was your child premature?	Yes, # weeks:	No
Ultrasounds during pregnancy?	Yes, number:	No
Medications during pregnancy?		
Medications during labour/ delivery?		
Where you induced?		
Was your child ever in any of the following positions? ☐ Breech ☐ Side lying ☐ Face/ brow presentation		
What type of delivery did you have?		
Any complications during delivery?		
Location of birth: ☐ Hospital ☐ Birth centre ☐ Home		
Child's weight at birth: Child's height at birth:		
Was your child breastfed? Yes, _____ months. No Or formula fed? Yes; Type:_____. Introduced to solid foods at _____ months. Cow's milk at _____ months.		

Family History:

Relative	**Living (age)**	**Health problems**	**Died (age)**	**Cause**
Mother				
Father				
Siblings (List):				
Grandmother (Mom's mom)				
Grandfather (Mom's dad)				
Grandmother (Dad's mom)				
Grandfather (Dad's dad)				
Other - specify (aunts, uncles, etc)				

Home life:

Please describe the child's home environment:
Has the child ever been under the care of a professional counselor, psychologist, social worker or other therapist? Please explain.
Please give a brief description of your child's personality:
Does your child exercise? Yes No What type of exercise?

Environment:

Is your child exposed to toxins or other hazards? (For example: cigarette or drug smoke, paint fumes, factories, pesticides, tar, exhaust, etc.) Please explain: Do they seem to react easily to chemicals?
Do you have any pets in the home? Yes No
List any known allergies: (Include foods, medications, environmental, animals, etc.)
Has your child ever traveled abroad? Yes No

Location	Age at time of travel

School Age Children:

Is your child home-schooled?	Yes	No
At what age did your child start school?		
Has your child ever been held back a grade?	Yes	No
What grade is your child currently in?		
Does your child enjoy school?	Yes	No
Has your child ever been diagnosed with a learning disability? If yes, please explain:	Yes	No
Describe your child's ability to interact socially with other children at school:		

Additional comments:

Thank you! It's time for your child's healing journey to begin…