KIANI Naturopathic Clinic

Core Link Wellness Centre
2238 Caroline St., Burlington, ON, L7R 1M5
Tel: 905.592.0095 Fax: 905.592.0106

# Pediatric Intake Form

Date:_____

Please complete the following form in order to provide us with the background information we require to ensure you receive comprehensive care.

Child's Name: _____ School Name: _____

Date of Birth: _____ School Phone: _____

Child's Age: _____ School Address: _____

Gender: _____ _____

List contact information in order of preference:

**Primary Contact:**

Name: _____ Home Phone: _____

Relationship to child: _____ Work Phone: _____

Address: _____ Cell Phone: _____

_____

**Secondary Contact:**

Name: _____ Home Phone: _____

Relationship to child: _____ Work Phone: _____

Address: _____ Cell Phone: _____

_____

## Chief Concerns:

List your main health concerns in order of importance

1. _____

_____

2. _____

Core Link Wellness Centre
2238 Caroline St., Burlington, ON, L7R 1M5
Tel: 905.592.0095 Fax: 905.592.0106

3. _____

## Medical History:

How would you describe your child's general state of health? (circle one)

Excellent Good Fair Poor

Please list any other medical providers:

| Type of Medical Provider | Name | Phone # | Address |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Please indicate any serious illnesses, conditions, or reasons for hospitalizations

| Medical Condition/Hospitalization | Date of Diagnosis | Is the condition still present? | Symptoms |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please list all current medications/supplements

| Medications/Supplements | Dose | Prescribing Physician | Length of use |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

KIANI Naturopathic Clinic

Core Link Wellness Centre
2238 Caroline St., Burlington, ON, L7R 1M5
Tel: 905.592.0095 Fax: 905.592.0106

Please indicate any allergies and/or food sensitivities

| Allergy/Food sensitivity | Symptoms |
|---|---|
| | |
| | |
| | |

Has your child taken antibiotics within the last 5 years (circle one)? YES NO

How many times has your child taken antibiotics within the last 5 years? _____

Vaccinations: Please indicate which vaccinations your child has received

| Vaccinations | Circle one | Any Adverse Effects |
|---|---|---|
| DPT (diphtheria, pertussis, tetanus) | Yes No | |
| MMR (measles, mumps, rubella) | Yes No | |
| Haemophilus influenza B | Yes No | |
| Hepatitis A | Yes No | |
| Hepatitis B | Yes No | |
| Chicken pox (varicella zoster) | Yes No | |
| Tetanus | Yes No | |
| Polio | Yes No | |
| Flu | Yes No | |
| Other | Yes No | |

Past conditions

| Conditions | Circle one | Age | Complications/Hospital Admittance |
|---|---|---|---|
| Asthma | Yes No | | |
| Ear Infections | Yes No | | |
| Chicken Pox | Yes No | | |
| Measles | Yes No | | |
| Mumps | Yes No | | |
| Rubella | Yes No | | |
| Strep throat | Yes No | | |
| Whooping cough | Yes No | | |
| Eczema | Yes No | | |
| Other | | | |

KIANI Naturopathic Clinic

Core Link Wellness Centre
2238 Caroline St., Burlington, ON, L7R 1M5
Tel: 905.592.0095 Fax: 905.592.0106

## Prenatal History:

What was the general health of the mother during pregnancy (circle one)?

Excellent Good Fair PoorUnknown

How was the mother's diet during pregnancy?

Excellent Good Fair Poor Unknown

Did the mother receive prenatal medical care (circle one)? Y N

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

Was the mother exposed to any of the following during pregnancy? (check the box next to the listed exposure)

| | | | |
|---|---|---|---|
| Alcohol | | Tobacco | |
| Recreational drugs | | Prescription medications | |
| Over the counter medications | | Other: | |

Pregnancy Complications: check the box next to the listed complications

| | | | | | |
|---|---|---|---|---|---|
| Nausea/vomiting | | High blood pressure | | Diabetes | |
| Bleeding | | Thyroid problems | | Other | |

Please indicate supplements taken during pregnancy:_____
_____

## Birth History:

Term length (circle one): Full term Premature: _____ wks Late: _____ wks

Length of labour: _____ Weight at birth: _____

Any complications: _____

_____

Please check the box to indicate:

| | | | | | |
|---|---|---|---|---|---|
| Vaginal | | Forceps | | Epidural/drugs | |
| Cesarean Section | | Suction | | Vacuum Extract | |

KIANI Naturopathic Clinic

Core Link Wellness Centre
2238 Caroline St., Burlington, ON, L7R 1M5
Tel: 905.592.0095 Fax: 905.592.0106

## Neonatal History:

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

| | | | | | |
|---|---|---|---|---|---|
| Neonatal jaundice | | Seizures | | Birth deformities | |
| Rash | | Birth injuries | | Other: | |

How would you rate your child's health in their first year (circle one)? Poor Fair Good Excellent

## Growth and Development:

Age child began to crawl _____ Age child began to teeth _____
Age child began to sit up _____ Age child began to talk _____
Age child began to walk _____

Sleep: hours per day: _____ hours per night: _____

## Feeding History:

Feeding (circle): breast fed bottle fed (Milk/Soy/Other): _____

Length of breast/bottle feeding: _____ age when solid foods were introduced:_____

Feeding complications: _____

What foods were introduced before 6 months: _____

List the solid foods introduced: _____

Does your child have any dietary restrictions (religious, vegetarian, vegan, etc.):_____

Please list any food cravings your child has: _____

Please list any food aversions your child has: _____

Describe a typical day's diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks/Beverages: _____

KIANI Naturopathic Clinic

Core Link Wellness Centre
2238 Caroline St., Burlington, ON, L7R 1M5
Tel: 905.592.0095 Fax: 905.592.0106

## Social History:

Is your child physically active? Yes No How much, how often? _____

How many hours of T.V. per day? ____ How many hours on computer? ____ How many hours outside? _____

Describe your child's behavior and performance at school:

_____

List the extracurricular activities your child is involved in or any favorite activities:

_____

## Family History:

Indicate if a close relative (parent, sibling) has had any of the following

| Condition | Circle one | Family Member |
|---|---|---|
| Allergies | YES NO | |
| Asthma | YES NO | |
| Diabetes | YES NO | |
| Heart Disease | YES NO | |
| Cancer | YES NO | |
| Depression | YES NO | |
| Other mental illness | YES NO | |
| Kidney disease | YES NO | |
| Other | YES NO | |
| Family History unknown | YES NO | |

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

_____

_____

Where did you learn about this clinic?

Friend/Family; name:_____
Internet:
- ☐ Google
- ☐ OAND/CAND
- ☐ Yellow pages (online)
- ☐ Canadian Naturopaths website

☐ Media
☐ Yellow pages book
☐ Seminars
☐ Robert Schad Naturopathic Clinic
☐ Other: _____