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PEDIATRIC INTAKE FORM – For Children under 12 years

File Number: \_\_\_\_\_ Date \_\_\_\_\_

Last Name: \_\_\_\_\_ First/Middle Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Female  Male  
mm/dd/yy

Your name: \_\_\_\_\_ Your relationship to the child: \_\_\_\_\_

Other parent/guardian name (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_  
Apt/House Number Street Name

\_\_\_\_\_ City Province Postal Code

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

May we leave phone messages relating to visits?  YES  NO

Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
Name Relation Phone Number

**Care Co-ordination**

Family Doctor: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Other Practitioners: \_\_\_\_\_

\_\_\_\_\_

Have you been treated by a Naturopathic Doctor before?  YES  NO

If yes, by whom? \_\_\_\_\_ When? \_\_\_\_\_

How would you describe your general state of health? (circle one) excellent good fair poor

**Health Concerns/History**

What is the main reason for your visit? \_\_\_\_\_

How long have you experienced this? \_\_\_\_\_

Is it getting better or worse over time? \_\_\_\_\_

*Please list your other health concerns or goals in order of importance*

When did it start?	Concerns/Goals	What treatments have you tried?

**Allergies and Sensitivities**

*Please list any known or suspected allergies, sensitivities, and/or intolerances to foods or drugs*


**Medications/Supplements**

*Please list all current medications and supplements including prescription drugs, over the counter drugs, herbs, vitamins, minerals, homeopathics, etc.*


**Past Prescriptions**

*Please list past prescription medications*


**Injuries, Surgeries, Hospitalizations**

*Please list any past serious injuries, surgeries, and hospitalizations*


## Immunizations

MMR (Measles, Mumps, Rubella)	Polio	Hepatitis A
DPT (Diphtheria, Pertussis, Tetanus)	Meningitis	Hepatitis B
Haemophilus Influenza B (Hib)	Smallpox	Rabies
Chicken Pox (Varicella Zoster)	Tetanus booster	Yellow Fever
Typhoid	Other:	Other:

Have you had adverse reactions to any vaccine?  YES  NO If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you taken antibiotics within the past 5 years?  YES  NO If yes, how many times? \_\_\_\_\_

## Past Medical History

Which of the following have you experienced? Indicate "C" for current, "P" for past or "F" for frequent:

Chicken Pox	Scarlet Fever	Tonsillitis
Measles	Pneumonia	Ear Infections
Mumps	Colds/Bronchitis	Sinus troubles
Rubella	Rheumatic Fever	Allergies
Asthma	Eczema/skin problems	Headaches
Digestive problems	Colic	Constipation/Diarrhea
Nausea/Vomiting	Growing pains/Scoliosis	Seizures
Attention Problems	ADD/ADHD	Bed Wetting

## Do you use any of the following?

Alcohol	Laxatives	Tea
Cigarettes	Antacids	Birth Control Pills
Recreational Drugs	Diet Pills	Hormone Therapy
Aspirin	Coffee	Other:

## Prenatal History

Were you premature?  YES  NO If yes, number of weeks? \_\_\_\_\_

Ultrasound during pregnancy?  YES  NO If yes, number of ultrasounds? \_\_\_\_\_

Medications during pregnancy?  YES  NO Medications during labour/delivery?  YES  NO

What type of delivery did you have? \_\_\_\_\_ Any complications during delivery?  YES  NO

Location of Birth:  Hospital  Birth Centre  Home Weight at birth: \_\_\_\_\_

Were you breastfed?  YES  NO If yes, for how many months? \_\_\_\_\_

Or formula fed?  YES  NO If yes, type? \_\_\_\_\_

At what age were you introduced to solid foods? \_\_\_\_\_

To cow's milk? \_\_\_\_\_

### Family History

Relative	Age	Health Problems	Died?	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)				

### General Information

Height \_\_\_\_\_ Weight \_\_\_\_\_

Have you lost or gained any weight in the last 6 months?  YES  NO If yes, how much? \_\_\_\_\_

Stress level at home (0 none, 10 extremely stressful): \_\_\_\_\_

Do you like school?  YES  NO Stress level at school (0 none, 10 extremely stressful): \_\_\_\_\_

What hobbies do you enjoy? \_\_\_\_\_

### Physical Activity

Do you exercise?  YES  NO If yes, what type and how often? \_\_\_\_\_

After exercise, do you generally feel:  Energized  Happily Fatigued  Tired  Exhausted

**Diet Type** (non-vegetarian, vegetarian, vegan...) \_\_\_\_\_ How long? \_\_\_\_\_

*Describe your typical daily diet*

Breakfast: \_\_\_\_\_

Snacks: \_\_\_\_\_

Lunch: \_\_\_\_\_

Beverages: \_\_\_\_\_

Dinner: \_\_\_\_\_

Water: \_\_\_\_\_

*Thank you!*