

# Holistic Healing Arts Centre

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www.ndoc.ca

## Pediatric Intake Form Dr. Alfred Hauk

Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Parents/ Guardians Name: \_\_\_\_\_ Phone: (H) \_\_\_\_\_

Occupation: \_\_\_\_\_ Phone: (B) \_\_\_\_\_

Address: ( If different from above)

Family Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

How did you hear about our Clinic?

### Child's Medical History

Chief Complaints:

\_\_\_\_\_

Specific Symptoms: \_\_\_\_\_

\_\_\_\_\_

Screening Tests Performed: \_\_\_\_\_

\_\_\_\_\_

Medications Taken: \_\_\_\_\_

\_\_\_\_\_

### Symptom Checklist

Put "C " for Current, or "P" for Past

Appetite Change \_\_\_\_\_ Bad Breath \_\_\_\_\_ Bed-wetting \_\_\_\_\_ Burning Urination \_\_\_\_\_

Constipation \_\_\_\_\_ Cough \_\_\_\_\_ Cries Easily \_\_\_\_\_ Visual Disturbances \_\_\_\_\_

Easy Bruising \_\_\_\_\_ Diarrhea \_\_\_\_\_ Dizziness \_\_\_\_\_ Hearing Loss \_\_\_\_\_

Sore Throat \_\_\_\_\_ Eczema \_\_\_\_\_ Fatigue \_\_\_\_\_ Indigestion \_\_\_\_\_

Urine Frequency \_\_\_\_\_ Nosebleeds \_\_\_\_\_ Night Sweats \_\_\_\_\_ Nervousness \_\_\_\_\_

Stomach Aches \_\_\_\_\_ Insomnia \_\_\_\_\_ Hair Loss \_\_\_\_\_ Vomiting \_\_\_\_\_

Wheezing \_\_\_\_\_

**Childhood Illnesses  
(Circle)**

Measles	Chicken Pox	Rubella	Mumps
Tonsillitis	Pneumonia	Frequent Colds	Ear Infections
Allergies	Fevers	Impetigo	Rheumatic Fever
Scarlet Fever	Anemia	Sinusitis	Acute Epiglottitis

Other:

**Immunizations  
(circle)**

Measles	Mumps	Rubella	Polio
Smallpox	Diphtheria	Pertussis	Tetanus
Influenza	Hepatitis		

Other:

Reactions to Immunizations:

**History**

Allergies:

Specific Allergy Tests Performed:

Medications Used in Childhood:

Circumcision?            YES                            NO

Surgery:

Anesthetics Use?            YES                            NO

Supplements Used:

Naturopathic Treatments:

### Family History

(Circle the conditions that have a history in your family, and give details below)

Alcoholism	Allergies	Asthma	Auto Immune Disorders
Cancer	Birth Defects	Diabetes	Muscular Dystrophy
Drug Abuse	Eczema	Heart Disease	Hypertension
Mental Illness	Osteoporosis	Psoriasis	Multiple Sclerosis
Tuberculosis	Rheumatoid Arthritis		

Details: \_\_\_\_\_

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

### Prenatal History

Mother's health during pregnancy:

Illness during pregnancy (circle):

Hypertension	Gestational Diabetes	Preeclampsia	Bleeding
Anemia	Excessive Vomiting	Trauma	

Other:

Mother's emotional health during pregnancy:

Substances during pregnancy (circle):

Tobacco	Alcohol	Caffeine
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Other: \_\_\_\_\_ How often: \_\_\_\_\_

Medications during pregnancy: \_\_\_\_\_

How much and how often? \_\_\_\_\_

Nutrition during pregnancy:

Supplements during pregnancy:

History of miscarriage or abortion:

## Natal History

Gestational Length: \_\_\_\_\_

Baby's length at birth: \_\_\_\_\_

Baby's weight at birth: \_\_\_\_\_

Duration of labor: \_\_\_\_\_

Type of labor (circle):

Spontaneous

Induced

If induced, Why?

Type of delivery:

Vaginal

C-Section

Complications during delivery:

Interventions used for labor & delivery: (circle):

Epidural

Forceps

Episiotomy

Catheter

Oxytocin

Prostaglandin Gel

Other:

Circle:

Home birth

or

Hospital birth

Midwife

or

Physician

## Neonatal History

Complications after delivery (circle):

Jaundice

Fever

Rash

Colic

Seizure

Birth Defects

Bleeding

Other:

## Sleep Patterns

Sleep patterns during the first year:

Has there been a history of bedwetting? YES NO

If YES, when did the bedwetting begin and end?

Night terrors? YES NO

Other sleep disturbances:

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## Milestones

Please indicate age accomplished:

Rolling Over

Crawling

Walking

Talking

Sitting

Standing

Teething

## Social History

Day-care? YES NO If yes, what age?\_\_\_\_\_

Reaction to day-care:

Present grade:\_\_\_\_\_

School performance:

Socialization skills:

Extracurricular activities:

What is your child's attitude towards authority?\_\_\_\_\_

## Feeding

Breast-fed: YES NO How long?

Bottle-fed: YES NO How long?

When were solid foods introduced? \_\_\_\_\_

First foods in order of introduction (please specify whether bottle, fresh and/or organic):

\_\_\_\_\_

Reactions to the foods above (i.e. colic, constipation, diarrhea, rash):

\_\_\_\_\_

Special diet? (i.e. vegetarian, vegan):

Present dietary concerns:

\_\_\_\_\_

Is your child a picky eater? \_\_\_\_\_ If yes, what foods?