Holistic Healing Arts

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Pediatric Intake Form
Dr. Mary-Leah Albano

Child's Name:_____ Today's Date:_____
Date of Birth:_____Age:_____Gender:_____
Address:_____
City:_____Province:_____Postal Code:_____
Phone #_____Email:_____

Parent/Guardians Name:_____Phone (H)_____

Occupation:_____Phone (B)_____
Address: (If different from above)_____Postal Code_____

Family Physician:_____Phone #_____

How did you hear about our clinic?_____

Does your insurance cover consultations with a Naturopathic doctor?_____Remedies Recommended?_____

Child's Medical History

Chief Complaints:_____
_____

Specific Symptoms:_____
_____

Screening Tests Performed:_____
_____

Medications Taken:_____
_____

Symptoms 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 Epigolottises

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 Used? 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 Disorder
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):

Tabacco	Alcohol	Caffeine

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 weight at birth:_____

Baby's length at birth_____Duration of labor:_____

Type of labor (circle)

Spontaneous Induced

If induced, Why?_____

Type of delivery (circle)

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 Pattern

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:_____
_____

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?_____

_____