Holistic Healing Arts

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Pediatric Intake Form
Dr. Simone Burke

Child's Name:____ Today's Date:_________________________
Date of Birth:______________________________Age:___________Sex: M F
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?____________
____