

HOLISTIC HEALING ARTS

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PEDIATRIC INTAKE FORM

DR. ONKAR SINGH

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 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 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
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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 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?_____
