

# HOLISTIC HEALING ARTS

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## PEDIATRIC INTAKE FORM

**Dr. Alexis Cole, ND**

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?\_\_\_\_\_