

HOLISTIC HEALING ARTS

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PEDIATRIC INTAKE FORM

DR. RANA SAMARA

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 |
|---------|---------|----------|

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?_____
