Red Deer Wellness Clinic
G12, 5550-45 Street, Red Deer, AB, T4N 1L1
403-346-1331

PEDIATRIC INTAKE FORM Today's Date:_____

To parent or guardian: Please take the time to fill out this form in as much detail as possible. When applicable, use your child's input to increase the accuracy of this intake. Every answer that you provide will help me to best address your child's health concerns. Also, your answers will be kept strictly confidential. Thank you.

Name:_____ Birthdate: _____
Age: _____ Gender: _____ Birthplace: _____
Address: _____

Mother's name or legal guardian: _____
Address: _____
Phone Number: Home: ( ) _____ Cell: ( ) _____ Work: ( ) _____
Email Address: _____

Father's name or legal guardian: _____
Address: _____
Phone Number: Home: ( ) _____ Cell: ( ) _____ Work: ( ) _____
Email Address: _____

Emergency contact name: _____
Address: _____
Phone Number: Home: ( ) _____ Cell: ( ) _____ Work: ( ) _____
Relationship: _____

Medical doctor's name: _____
Address and phone number: _____

Source of Referral? (friend, advertisement, doctor, etc): _____

Chief Concern # 1
Description: _____
When did it start? _____
What makes it better? _____
What makes it worse? _____
What therapies/medications have been used? _____

Chief Concern # 2
Description: _____
When did it start? _____
What makes it better? _____
What makes it worse? _____
What therapies/medications have been used? _____

Chief Concern # 3
Description: _____
When did it start? _____
What makes it better? _____
What makes it worse? _____
What therapies/medications have been used? _____

Medical History:

Childhood illnesses (fill in the age of occurrence and severity of illness)

ILLNESS	AGE	MILD	AVERAGE	SEVERE
Chicken pox				
Mumps				
Measles				
German Measles				
Scarlet Fever				
Mononucleosis				
Ear Infections				

Others (note age and severity with it as well): _____
Surgeries or operations (what and when): _____
Hospitalizations (why and when): _____
Broken bones or severe sprains (where and when): _____
Allergies (medications, food, environmental): _____

Medications
Past (how long ago and duration): _____
_____
Present (and duration): _____
_____
Supplements, homeopathics, herbs
Past (how long ago and duration): _____
_____
Present (and duration): _____

Diet:
Typical daily diet (be as detailed as possible)
Breakfast _____
Lunch _____
Supper _____
Snacks _____
Juice or pop intake _____
Water intake _____

Family History: (write family members in box beside the condition)

Cancers (specify type)		High Cholesterol	
Heart Disease		Intestinal problems	
Hypertension		Addictions	
Strokes		Psychological problems	
Kidney diseases		Diabetes	
Epilepsy		Bleeding Disorders	
Lung problems (asthma, emphysema, etc)		Allergies	
Arthritis		Others:	

Immunization History:

IMMUNIZATION	DATES	ANY REACTION	IMMUNIZATION	DATES	ANY REACTION
Measles			Small pox		
Mumps			Polio		
Rubella			Whooping Cough		
Diptheria			Spinal Meningitis		
Tetanus			Other		

Prenatal History:

Mother's health:

Health status (just before and during pregnancy): _____

Age at conception: _____ Duration of pregnancy (weeks):_____

Maximum weight gain during pregnancy:):_____

Use of any medications: _____

smoking, drugs or alcohol (how much): _____

supplements : _____

Symptoms during pregnancy: (please check if applicable)

- □ heartburn how long: _____ severity: _____
- □ nausea/vomitting how long: _____ severity: _____
- □ hypertension maximum blood pressure: _____
- □ diabetes maximum glucose reading: _____
- □ trauma description: _____
- □ other _____

Emotional state while pregnant: _____

Diet:

Breakfast _____

Lunch _____

Supper _____

Snacks _____

Any cravings (if so, what were they and how often)? _____

Exercise (amount and types):_____

Father's heath just before conception: _____ Age:_____

Natal History: (during delivery)

Delivery (vaginal or C-section): _____

Any medications? (painkillers, inducers): _____

Forceps or suction used? _____

Any complications? _____

How many hours spent in labour? _____

Neonatal and Infancy:

APGAR rating: 1 min____ 5 min. ____ Weight: _____ Length: _____

Any problems with child's health? _____

Breastfed or formula? (how long): _____

If formula, what kind and brand name: _____

Introduction of food:

What age was the first food introduced? _____

What were the first foods? _____

Any noticeable reactions or health concerns around this time? _____

Any allergies discovered? _____

How was the child's health after one year of age? _____

Developmental History:

MILESTONE	AGE	MILESTONE	AGE
Held up head		Said first word	
Rolled over		Said several words together	
Crawled		Said a sentence	
Sat up with support		Tied own shoes	
Sat up alone		Got dressed alone	
Walked with support		Fully toilet trained	
Walked alone		Rides a tricycle	

Social History:

Education level:_____ Which school attended:_____
General performance in academics: _____
Does child enjoy school/teachers? _____
Any learning disabilities:_____ date of testing: _____
Extracurricular activities: _____
Hobbies: _____
Sports involvement: _____
Fears/worries about school: _____
Describe relationships with friends: _____

Home life:

Any pets/animals (what kind): _____
Kind of heating used? (gas, oil, forced air, electric, etc) _____
Is the house air conditioned? _____
Household stress level (1-10, 10 being the highest amount of stress) _____
How many people living in the house? _____
Siblings' names and ages: _____
Does anyone in the house smoke? (if yes, who) _____
Any concerns about lead exposure? (old home/plumbing/peeling paint) _____
Fears/worries about home life/neighbourhood: _____
Behaviors/habits (nail biting, thumb sucking, tics, etc): _____
Number of hours watching TV: _____ playing videogames: _____ computer: _____
Favourite thing to do: _____
Least favourite thing to do: _____

Travelling:

All the places travelled, when and how long for: _____
Locations of places lived, when and for how long: _____
Any sicknesses during vacations or shortly afterwards: _____

Sleep:

How many hours a night? _____
Time of bedtime:_____ Time of getting up:_____ Is this consistent?_____
Sleeps through the night? _____
Position preferred during sleep (back, abdomen): _____
Covers on or off? _____
Hot or cold room preferred? _____
Is there a humidifier in the room? _____
Bedwetting: _____ Teeth grinding: _____
Nightmares (describe any that reoccur): _____
Any problems with sleeping at anytime throughout life: _____

Personality:

Describe your child using five words/phrases:

1. _____
2. _____
3. _____
4. _____
5. _____

Is there anything else that you would like to tell your Naturopathic Doctor?

_____
_____
_____

Review of Systems: (please circle the appropriate answer and add any additional comments)

This section is designed to pick up any other concerns that may have been missed earlier.

Y – a condition you have now
N – a condition you have NEVER had
P – a condition you have had in the past

General:

Weight _____ Height _____ Maximum weight _____ Weight one year ago _____
Energy level (1-10, 10 being the most energy ever) _____

		Time of onset and how often
Fevers/chills	Y N P	_____
Excessive thirst, sweating, hunger	Y N P	_____
Skin:		
Rashes, eczema, itching, hives	Y N P	_____
Acne	Y N P	_____
Lumps	Y N P	_____
Colour change	Y N P	_____
Dryness, moistness	Y N P	_____
Temperature changes	Y N P	_____
Herpes	Y N P	_____
Jaundice	Y N P	_____
Nail changes	Y N P	_____
Bruise easily	Y N P	_____
Head:		
Headache	Y N P	_____
Head injury	Y N P	_____
Dizziness	Y N P	_____
Enlarged lymph nodes	Y N P	_____
Eyes:		
Glasses or contacts	Y N P	_____
Eye pain	Y N P	_____
Double vision, blurriness	Y N P	_____
Tearing or dryness	Y N P	_____
Bothered by sun	Y N P	_____
Redness, itching	Y N P	_____
Blind spots	Y N P	_____
Ears:		
Infections	Y N P	_____
Ear pain	Y N P	_____
Hearing impairment	Y N P	_____
Nose and Sinuses:		
Frequent colds (more than 3/yr)	Y N P	_____
Nose bleeds	Y N P	_____
Stuffiness or allergies	Y N P	_____
Mouth and Throat		
Frequent sore throat (more than 3/yr)	Y N P	_____
Gum problems	Y N P	_____
Cavities/fillings	Y N P	_____
Enlarged tonsils	Y N P	_____
Neck:		
Pain or stiffness	Y N P	_____
Lumps	Y N P	_____
Respiratory:		
Cough	Y N P	_____
Asthma	Y N P	_____
Bronchitis, pneumonia	Y N P	_____
Painful breathing	Y N P	_____

Cardiovascular:		
Chest pain	Y N P	_____
Palpitations, fluttering	Y N P	_____
Gastrointestinal:		
Trouble swallowing	Y N P	_____
Abdominal pain	Y N P	_____
Indigestion	Y N P	_____
Belching, gas, bloating	Y N P	_____
Nausea/vomiting	Y N P	_____
Diarrhea	Y N P	_____
Constipation	Y N P	_____
Changes in appetite	Y N P	_____
Bowel movements:		
How often? _____		
Colour of stool _____		
Are they formed?	Y N P	_____
Any undigested food in it?	Y N P	_____
Do they float?	Y N P	_____
Do they smear on the toilet?	Y N P	_____
Any mucous or blood?	Y N P	_____
Has the stool ever been black?	Y N P	_____
Urinary:		
Pain on urination	Y N P	_____
Increased frequency	Y N P	_____
Inability to hold urine	Y N P	_____
Frequency at night	Y N P	_____
Blood in urine	Y N P	_____
Male Reproductive:		
Testicular pain	Y N P	_____
Discharge or sores	Y N P	_____
Testicular swellings	Y N P	_____
Female Reproductive:		
Vaginal pain	Y N P	_____
Discharge or sores	Y N P	_____
Vaginal itching, infection	Y N P	_____
Musculoskeletal:		
Joint pain or stiffness	Y N P	_____
Weakness	Y N P	_____
Muscle spasms or cramps	Y N P	_____
Peripheral Vascular:		
Cold hands or feet	Y N P	_____
Extremity numbness	Y N P	_____
Extremity swelling	Y N P	_____
Varicose veins	Y N P	_____
Neurological:		
Fainting	Y N P	_____
Seizures/convulsions	Y N P	_____
Twitches or involuntary movement	Y N P	_____
Paralysis	Y N P	_____
Loss of memory	Y N P	_____
Loss of balance	Y N P	_____
Speech problems	Y N P	_____
Emotional:		
Depression	Y N P	_____
Mood swings	Y N P	_____
Anxiety/nervousness	Y N P	_____
Phobias	Y N P	_____
Insomnia	Y N P	_____

PLEAE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used, in order to stimulate the body's inherent healing capacity. During the appointment a thorough case history will be done, as well as a physical examination, urine sample and Naturopathic assessment.

It is very important that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from, known allergies, and if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding; please advise your Naturopathic Doctor immediately.

There are some slight health risks to treatment by Naturopathic medicine. These include, but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from acupuncture or injection/IV therapies
- Fainting or puncturing of an organ with acupuncture needles

I understand that my identity will be protected and confidential at all times and if necessary, identifying information will be altered to protect my privacy. I understand that a record will be kept of the health services provided to me and other health care professionals may have access to my medical records, which I may choose to decline that access at any time. The record will not be released to others, unless so directed by myself or the law requires it. I understand that all my medical records will be kept securely by my Naturopathic Doctor and are made available at my request. If my primary Naturopathic Doctor moves his/her practice from the Red Deer Wellness Clinic, I will be notified of appropriate contact information to access my records. My medical records will be maintained and accessible for a minimum of:

- 10 years from the date of last record entry for an adult client; or
- 10 years after the date of last record entry for a minor client, or 2 years after the client reaches or would have reached the age of 18, whichever is longer.

The clinic provides access to a professional dispensary for you to purchase remedies that the Naturopathic Doctors have prescribed, but are NOT mandatory to purchase. Alternate options will be provided if available.

If an appointment is missed without 24 hour notice, I agree to give my credit card to reschedule an appointment. If I do not attend my next appointment, I agree to pay 50% the appointment cost. My card number will be kept confidential and destroyed appropriately.

I understand that the results are not guaranteed. I expect the Naturopathic Doctor to be able to anticipate and explain all known benefits, risks and alternatives to treatment. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, **except** for _____.

I intend this consent form to cover the entire course of treatment for my health conditions. I understand that I am free to voice my concerns or withdraw my consent and to discontinue participation in these procedures or treatments at any time.

Client's Name: (Please Print) _____

Signature of Client or Guardian: _____

Date: _____ Signature of Naturopathic Doctor _____