KIANI Naturopathic Clinic

Core Link Wellness Centre
2238 Caroline St., Burlington, ON, L7R 1M5
Tel: 905.592.0095 Fax: 905.592.0106

Pediatric Intake Form

Date:_____

Please complete the following form in order to provide us with the background information we require to ensure you receive comprehensive care.

Child's Name: _____ School Name: _____

Date of Birth: _____ School Phone: _____

Child's Age: _____ School Address: _____

Gender: _____ _____

List contact information in order of preference:

Primary Contact:

Name: _____ Home Phone: _____

Relationship to child: _____ Work Phone: _____

Address: _____ Cell Phone: _____

_____

Secondary Contact:

Name: _____ Home Phone: _____

Relationship to child: _____ Work Phone: _____

Address: _____ Cell Phone: _____

_____

Chief Concerns:

List your main health concerns in order of importance

1. _____

_____

2. _____

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_____

_____

3. _____

_____

Medical History:

How would you describe your child's general state of health? (circle one)

Excellent Good Fair Poor

Please list any other medical providers:

Type of Medical Provider	Name	Phone #	Address

Please indicate any serious illnesses, conditions, or reasons for hospitalizations

Medical Condition/Hospitalization	Date of Diagnosis	Is the condition still present?	Symptoms

Please list all current medications/supplements

Medications/Supplements	Dose	Prescribing Physician	Length of use

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Please indicate any allergies and/or food sensitivities

Allergy/Food sensitivity	Symptoms

Has your child taken antibiotics within the last 5 years (circle one)? YES NO

How many times has your child taken antibiotics within the last 5 years? _____

Vaccinations: Please indicate which vaccinations your child has received

Vaccinations	Circle one	Any Adverse Effects
DPT (diphtheria, pertussis, tetanus)	Yes No	
MMR (measles, mumps, rubella)	Yes No	
Haemophilus influenza B	Yes No	
Hepatitis A	Yes No	
Hepatitis B	Yes No	
Chicken pox (varicella zoster)	Yes No	
Tetanus	Yes No	
Polio	Yes No	
Flu	Yes No	
Other	Yes No	

Past conditions

Conditions	Circle one	Age	Complications/Hospital Admittance
Asthma	Yes No		
Ear Infections	Yes No		
Chicken Pox	Yes No		
Measles	Yes No		
Mumps	Yes No		
Rubella	Yes No		
Strep throat	Yes No		
Whooping cough	Yes No		
Eczema	Yes No		
Other			

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Prenatal History:

What was the general health of the mother during pregnancy (circle one)?

Excellent Good Fair PoorUnknown

How was the mother's diet during pregnancy?

Excellent Good Fair Poor Unknown

Did the mother receive prenatal medical care (circle one)? Y N

What was the mother's age at child's birth? _____

Was the mother exposed to any of the following during pregnancy? (check the box next to the listed exposure)

Alcohol		Tobacco	
Recreational drugs		Prescription medications	
Over the counter medications		Other:	

Pregnancy Complications: check the box next to the listed complications

Nausea/vomiting		High blood pressure		Diabetes	
Bleeding		Thyroid problems		Other	

Please indicate supplements taken during pregnancy:_____
_____

Birth History:

Term length (circle one): Full term Premature: _____ wks Late: _____ wks

Length of labour: _____ Weight at birth: _____

Any complications: _____

_____

Please check the box to indicate:

Vaginal		Forceps		Epidural/drugs	
Cesarean Section		Suction		Vacuum Extract	

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Neonatal History:

Did the child experience any of the following at or shortly after birth?

Neonatal jaundice		Seizures		Birth deformities	
Rash		Birth injuries		Other:	

How would you rate your child's health in their first year (circle one)? Poor Fair Good Excellent

Growth and Development:

Age child began to crawl _____ Age child began to teeth _____
Age child began to sit up _____ Age child began to talk _____
Age child began to walk _____

Sleep: hours per day: _____ hours per night: _____

Feeding History:

Feeding (circle): breast fed bottle fed (Milk/Soy/Other): _____

Length of breast/bottle feeding: _____ age when solid foods were introduced:_____

Feeding complications: _____

What foods were introduced before 6 months: _____

List the solid foods introduced: _____

Does your child have any dietary restrictions (religious, vegetarian, vegan, etc.):_____

Please list any food cravings your child has: _____

Please list any food aversions your child has: _____

Describe a typical day's diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks/Beverages: _____

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Social History:

Is your child physically active? Yes No How much, how often? _____

How many hours of T.V. per day? ____ How many hours on computer? ____ How many hours outside? _____

Describe your child's behavior and performance at school:

_____

List the extracurricular activities your child is involved in or any favorite activities:

_____

Family History:

Indicate if a close relative (parent, sibling) has had any of the following

Condition	Circle one	Family Member
Allergies	YES NO	
Asthma	YES NO	
Diabetes	YES NO	
Heart Disease	YES NO	
Cancer	YES NO	
Depression	YES NO	
Other mental illness	YES NO	
Kidney disease	YES NO	
Other	YES NO	
Family History unknown	YES NO	

Is there anything that you feel is important that has not been covered?

_____

_____

Where did you learn about this clinic?

Friend/Family; name:_____
Internet:
- ☐ Google
- ☐ OAND/CAND
- ☐ Yellow pages (online)
- ☐ Canadian Naturopaths website

☐ Media
☐ Yellow pages book
☐ Seminars
☐ Robert Schad Naturopathic Clinic
☐ Other: _____