Apple Naturopathic Clinic
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Pediatric Intake Form (Birth – 5 Years)

Patient's name: _____ Date of first visit: _____
Age: ___ Date of Birth: ___/___/____ Gender: female male
Mother's name: _____ Father's name: _____
Address: _____ City: _____ Province: _____ Postal:_____
Phone # (home): (_____)_____ Parents # (work): (_____)_____
Parents e-mail address: _____
How did you hear about our clinic? _____
Name of Dr.'s Office/Hospital/Clinic where your child's health records are kept:
_____
Reason for referral or presenting problems: _____

MEDICATIONS	Now	Past		Now	Past
Aspirin	____	____	Antibiotics	____	____
Tylenol	____	____	Anti-histamine	____	____
Decongestant	____	____	Other	____	____
Ibuprofin	____	____	Allergies to medicines _____		

MEDICAL HISTORY

____ Chicken pox ____ Scarlet fever ____Tonsillitis, approx. no. _____
____ Measles ____ Pneumonia ____ Ear infections, no. _____
____ Mumps ____ Frequent colds ____ other (please list) _____
____ Rubella ____ Rheumatic fever

Has your child had any of the following tests? When Where Results
Electroencephalogram _____
Psychological evaluation _____
Hearing _____
Speech/Language _____
Injuries/Surgeries/Hospitalizations (please list): _____
_____

IMMUNIZATIONS

_____ Measles _____ Polio _____ MMR _____ Smallpox _____ Diphtheria
_____ Mumps _____ DPT _____ Tetanus _____ Influenza _____ Other
Any adverse reactions? Y N If yes, please explain _____

FAMILY HISTORY

_____ Heart disease _____ Diabetes _____ Birth defects _____ Cancer
_____ Hypertension _____ Arthritis _____ Mental illness _____ Allergies

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications? _____
_____

Mother's age at child's birth? _____

Mother's health during pregnancy?

_____ Bleeding _____ Physical or emotional trauma
_____ Nausea _____ Cigarettes, alcohol, drug consumption
_____ Illnesses _____ Medications
_____ Hypertension _____ Thyroid problems _____ Diabetes

BIRTH HISTORY

Term: Full _____ Premature _____ Late _____ Weight at birth _____
Length of labor _____ Complications? _____
Did your child have any of the following problems shortly after birth?

____ Birth defects ____ Birth injuries ____ Blue baby
____ Cerebral palsy ____ Seizures ____ Jaundice
____ Colic ____ Fever ____ Rashes

Other (explain) _____
Child's sleep patterns (first year) _____
Food intolerances (if any) _____
Feeding: Breast fed? _____ how long?_____ Formula?_____ milk / soy
Age began solids _____Which foods? _____
Age began: Sitting _____ Crawling _____ Walking _____Talking _____

SYMPTOMS (mark **Y** if current, **P** significant past symptom)

____ Hives ____ Burning of urine ____ Bloody urine
____ Eczema ____ Frequent urination ____ Cries easily
____ Bleeding gums ____ Heart murmur ____ Nervous
____ Nose bleeds ____ Vomiting spells ____ Sleep problems
____ Acne ____ Anemia ____ Night sweats
____ High fevers ____ Stomach aches ____ Sensitive to light
____ Chronic rash ____ Jaundice ____ Body/breath odor
____ Hearing loss ____ Easy bruising ____ Motion/car sickness
____ Diarrhea ____ Flat feet ____ No appetite
____ Sore throats ____ Constipation ____ Nightmares
____ Headaches ____ Gas ____ Canker sores
____ Frequent colds ____ Bleeding tendency ____ Unusual fears
____ Wheezing ____ Joint pains ____ Excessive fatigue
____ Cough ____ Dizzy spells ____ Hair loss

DIET

Please describe your child's typical daily diet:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
To Drink: _____

Thank you. I look forward to helping your child in any way I can.