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	____	____
Ibuprofen	____	____	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.