1281 Shoppers Row
Campbell River, BC V9W 2C7
Tel: (250) 287-7429
Fax: (250) 287-1133

PEDIATRIC INTAKE FORM (Birth to 12 years)

Naturopathic medical care requires a healthy relationship between provider and patient. Your responses to the following questions will significantly contribute to your doctor's understanding of you and your health history. ***Please complete in as much detail as you feel is relevant and to the degree that you are comfortable.*** *Thank you!*

PERSONAL INFORMATION:

Child's First Name: _____ Last Name: _____

Date of Birth (mm/dd/yy): ____/____/____ Age: _____ Gender: MALE / FEMALE

MSP Care Card #: _____ Extended Coverage: YES / NO

Contacts (in order of preference):

1) Name: _____ Relationship to Child: _____

Address: _____ City: _____ Province: _____

Postal Code: _____ Email: _____

Phone # (H): _____ (Cell): _____ (W): _____

2) Name: _____ Relationship to Child: _____

Address: _____ City: _____ Province: _____

Postal Code: _____ Email: _____

Phone # (H): _____ (Cell): _____ (W): _____

3) Name: _____ Relationship to Child: _____

Address: _____ City: _____ Province: _____

Postal Code: _____ Email: _____

Phone # (H): _____ (Cell): _____ (W): _____

4) Name: _____ Relationship to Child: _____

Address: _____ City: _____ Province: _____

Postal Code: _____ Email: _____

Phone # (H): _____ (Cell): _____ (W): _____

Okay to leave a message re: appointments? (Please circle) YES / NO

Contact person for appointment reminders: _____ Tel: _____

With whom does the child live with? _____

How did you hear about our clinic? (Please check box)

Current patient of CR Chiropractic _____ Advertising _____
Medical Doctor/Specialist (please provide name): _____ Website (campbellriverchiropractic.ca OR vitalrootswellness.ca)
Other Health Care Provider (please provide name): _____ Information Session _____
CR Chiropractic Staff _____ Social Media (Facebook, Twitter, etc) _____
Other: _____

VITAL ROOTS Wellness

1281 Shoppers Row
Campbell River, BC V9W 2C7
Tel: (250) 287-7429
Fax: (250) 287-1133

Name: _____ *Date of Birth:*

Child's Primary Care Provider (ie. Pediatrician, Medical Doctor): _____ Clinic Number: _____

Please list other health care providers the child is currently seeing or working with:

Practitioner Name: _____ Practitioner Type: _____ Contact #: _____

Practitioner Name: _____ Practitioner Type: _____ Contact #: _____

Practitioner Name: _____ Practitioner Type: _____ Contact #: _____

What expectations do you have of me as your child's physician?

_____

What expectations do you have from this first visit to our clinic?

_____

What is your **main reason** for seeking naturopathic care? If your child has a specific health condition, please describe it in detail. (Eg. When was the first time you noticed the condition and describe any factors that you suspect may have played a role in its onset and continuation.)

_____

_____

Child's current health concerns, listed in order of preference:

1) _____ 2) _____

3) _____ 4) _____

How would you rate your child's overall health? POOR FAIR AVERAGE GOOD EXCELLENT

How would you rate your child's overall energy? POOR FAIR AVERAGE GOOD EXCELLENT

MEDICAL HISTORY (please check)

Chicken pox:	_____	Pneumonia:	_____	Strep throat:	_____
Measles:	_____	Whooping Cough:	_____	Ear Infections:	_____
Mumps:	_____	Rheumatic fever:	_____	Mononucleosis:	_____
Rubella:	_____	Roseola:	_____	Impetigo:	_____
Scarlet fever:	_____	Bronchiolitis/Bronchitis:	_____	Other (please list):	_____

Serious Illnesses/Injuries/Surgeries/Hospitalizations (please list):

_____

_____

_____

MEDICATIONS:

Please indicate whether your child on any medication (prescription and over-the counter):

_____

_____

Approximately how many times has your child been treated with antibiotics? _____

Has your child ever had an adverse reaction to a medication? Y / N List the Medication: _____

1281 Shoppers Row
Campbell River, BC V9W 2C7
Tel: (250) 287-7429
Fax: (250) 287-1133

Name: _____ *Date of Birth:* _____

ALLERGIES:

List all (medications, pollens, foods, animals etc.):

_____

_____

OVER THE COUNTER REMEDIES/SUPPLEMENTS:

List all remedies/supplements (herbal, vitamin/mineral, nutritional, homeopathic etc.) your child is taking:

1.	3.
2.	4.

IMMUNIZATIONS (please check)

MMR (measles, mumps, rubella) _____ Haemophilus influenza B _____ Meningococcal (meningitis) _____
Polio _____ Hepatitis B _____ Varicella (chicken pox) _
DPT (diphtheria, pertussis, tetanus) _____ Hepatitis A _____ Rotavirus _____
Influenza (Flu) _____ Tetanus booster? When? _____ Other: _____
Smallpox _____ Pneumococcal (pneumonia) _____

Any adverse reactions to vaccines: Y / N If yes, please describe: _____

PRENATAL HISTORY

The health of birth parents at conception (please circle):

Mother: POOR FAIR AVERAGE GOOD EXCELLENT
Father: POOR FAIR AVERAGE GOOD EXCELLENT

Mother's health during pregnancy? (please circle)

POOR FAIR AVERAGE GOOD EXCELLENT

Mother's age at child's birth? _____

Were any of the following experienced during pregnancy?

Bleeding: _____ Emotional trauma: _____
Nausea: _____ High blood pressure: _____
Vomiting: _____ Thyroid problems: _____
Physical trauma: _____ Gestational diabetes: _____
Other: _____

Did the mother use any of the following during the pregnancy?

Tobacco: _____ Alcohol: _____ Recreational Drugs (please specify): _____
Prescription Medications (please specify): _____
Over the counter medications (please specify): _____
Supplements (please specify): _____

Did the mother experience any illnesses during the pregnancy? (please specify)

_____

CHILD'S BIRTH HISTORY

Term: (please circle) FULL PREMATURE: _____ wks OVERDUE: _____ wks
Weight at birth: _____ Length at birth: _____

1281 Shoppers Row
Campbell River, BC V9W 2C7
Tel: (250) 287-7429
Fax: (250) 287-1133

Name: _____ *Date of Birth:* _____

Birth: (please check any that apply)

Vaginal: _____ Sweeping of the membranes: _____
C-section: _____ Amniotomy/AROM: _____
Pitocin drip: _____ Forceps: _____
Cervidil (prostaglandins): _____ Vacuum: _____

Any complications? _____

Did your child have any of the following problems shortly after birth? (please check all that apply)

Birth abnormality
Cerebral palsy
Colic
Birth injuries
Seizures
Fever
Blue baby
Jaundice
Rashes
Other (explain): _____

DIET

How was your infant fed:

Breastfed? _____ How long? _____
Formula? _____ Type: (please circle) MILK SOY OTHER: _____
Other? _____

What foods were introduced before 6 months? (please also specify approximate month)

_____
_____
_____

What foods were introduced between 6-12 months?

_____
_____
_____

Did your child ever experience colic? Y / N How Severe? Mild Moderate Severe

Does your child have any food intolerances or allergies? Please list.

_____
_____
_____

Does your child have any dietary restrictions (religious, vegan/vegetarian, etc.)?

_____
_____
_____

Describe a typical days diet:

Breakfast _____
Snack _____
Lunch _____
Snack _____
Dinner _____
Beverages (including quantity) _____

1281 Shoppers Row
Campbell River, BC V9W 2C7
Tel: (250) 287-7429
Fax: (250) 287-1133

Name: _____ *Date of Birth:* _____

HEALTH AND DEVELOPMENT

How was your child's health in the first year? (circle) POOR FAIR GOOD EXCELLENT UNKNOWN

Describe your child's sleep patterns _____

_____

How would you describe your child's temperament? _____

_____

Environmental allergies (if known) _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

How would you describe your child's behavior and performance at school? _____

_____

ENVIRONMENT

Is the child in: (please check) SCHOOL DAYCARE HOME CARE OTHER: _____

What are your child's favorite activities? _____

_____

Does your child exercise regularly? Y / N How much, how often?

_____

_____

How much television does your child watch? _____hrs a day/week

How often does your child read (not for school), or how often does someone read to your child? (please circle)

DAILY SEVERAL TIMES A WEEK WEEKLY LESS THAN WEEKLY

Does anyone in the child's household smoke? Y / N Are there animals in the home? Y / N

How is the child's home heated?

Natural Gas _____ Wood _____

Oil _____ Other: _____

Electric _____

Do you know of any toxins the child is regularly exposed to (home, other's work, hobbies, etc.)? Please describe.

_____

_____

_____

How would you describe the emotional climate of your home?

_____

_____

_____

1281 Shoppers Row
Campbell River, BC V9W 2C7
Tel: (250) 287-7429
Fax: (250) 287-1133

Name: _____ *Date of Birth:* _____

REVIEW OF SYSTEMS:

GENERAL SYMPTOMS:	**EARS/EYES/NOSE/THROAT:**	**CARDIOVASCULAR:**
Headache	Tonsillitis	Heart murmur
Head injury	Sore Throat	Irregular heart beat
High fevers	Enlarged Glands	Irregular Heart Beat
Chills	Ear discharge	Bleeding gums
Night Sweats	Ear infections	Anemia
Dizzy spells	Mastoiditis	**GASTROINTESTINAL:**
Fainting	Hearing loss	Bloating
Excessive Fatigue	Nose bleeds	Excessive thirst
Nervousness/Anxiety	Ear ache	Excessive hunger
Loss of Weight	Nasal Discharge	Reflux
Allergies	Nose bleeds	No appetite
Nightmares	Sensitivity to light	Belching
Sleep problems	Bad breath odor	Gas (flatulence)
Cries easily	Canker sores	Nausea
Unusual fears	Bleeding gums	Vomiting Spells
Motion/car sickness	**MUSCLE & JOINT:**	Stomach Aches
SKIN:	Spinal scoliosis	Abdominal Cramps
Change in mole(s)	Muscle weakness	Constipation
Hives / allergic reactions	Joint Pains	Diarrhea
Acne / skin eruptions	Painful tailbone	Jaundice
Itching (ears, skin, rectum)	Flat feet	Irritable Bowel syndrome
Bruising easily	**KIDNEYS/REPRODUCTIVE:**	**RESPIRATORY:**
Dryness	Inability to control urine	Asthma
Sensitive skin	Frequent urination	Wheezing
Eczema	Painful urination	Cough
Body odor	Bedwetting	Frequent colds
Hair loss	Kidney infection	**OTHER:**
	Bloody urine	

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

_____

_____

_____

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