

# Naturopathic Pediatric Intake Form



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## PATIENT INFORMATION

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
Birth date: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Apt: \_\_\_\_\_  
Town/City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Home Phone Number: \_\_\_\_\_  
Names of Parents/Legal Guardians: \_\_\_\_\_  
Primary Care Physician & Telephone Number: \_\_\_\_\_  
Pediatrician & Telephone Number: \_\_\_\_\_

## CHIEF CONCERNS

**PRESENT HEALTH CONCERNS:** Please list your most important health concerns:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Can you trace the origin of the present illness to any particular circumstance, accident, illness, incident, mental upset or unusual stress in your life? If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_

## HEALTH HISTORY

Please put an 'N' for any conditions that your child experiences now, and a 'P' for any conditions that your child has experienced in the past:

- |   |  |
|---|--|
| <input type="checkbox"/> Ear Infections               | <input type="checkbox"/> Chronic Colds     |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Sinus Problems    |
| <input type="checkbox"/> Allergies                    | <input type="checkbox"/> Seizures          |
| <input type="checkbox"/> Digestive Problems           | <input type="checkbox"/> Recurring Fevers  |
| <input type="checkbox"/> Colic                        | <input type="checkbox"/> Chicken Pox       |
| <input type="checkbox"/> Upper Respiratory Infections | <input type="checkbox"/> Headaches         |
| <input type="checkbox"/> Skin Problems                | <input type="checkbox"/> Bed Wetting       |
| <input type="checkbox"/> Constipation                 | <input type="checkbox"/> Coughing/Wheezing |
| <input type="checkbox"/> Diarrhea                     | <input type="checkbox"/> Measles           |
| <input type="checkbox"/> ADD/ADHD                     | <input type="checkbox"/> Mumps             |

Mononucleosis  
 Strep Throat  
 Pneumonia  
 Whooping Cough

Influenza  
 Anxiety  
 Cystitis

Other: \_\_\_\_\_

Are there any chemicals, fumes, or dusts that you believe your child has been or may currently be exposed to? \_\_\_\_\_

**MEDICATIONS**

Current prescription and non-prescription medications:


Past medications, length of time taken, and reason:


Nutritional and other health supplements:


Please list vaccinations and any reactions noted:


**PAST SURGERIES/HOSPITALIZATIONS**

**Please list previous medical procedures, hospitalizations, major injuries and serious illnesses:**

Approximate date/year	Surgery/hospitalizations/procedure/serious illness/injuries

**FAMILY HISTORY**

Indicate if a close relative (mother, father, grandmother, grandfather, daughter, son, sister, brother) has had any of the following:

Condition	Who	Condition	Who
Allergies		Depression	

Asthma		Other mental illness	
Heart disease		Drug or alcohol abuse	
High blood pressure		Kidney disease	
Cancer		Thyroid disorder	
Diabetes		Other	

Any known genetic diseases. If yes, please explain

\_\_\_\_\_

I do not know my family medical history

### **PRENATAL HISTORY**

Name of Midwife/Obstetrician:

\_\_\_\_\_

Location of the birth:

\_\_\_\_\_

Length of term:

\_\_\_\_\_

Birth length and weight:

\_\_\_\_\_

Medications taken during pregnancy:

\_\_\_\_\_

Medications taken during labour/delivery:

\_\_\_\_\_

Was any alcohol consumed during the pregnancy? If yes, how much? When?

\_\_\_\_\_

Did you smoke or were you exposed to second hand smoke during the pregnancy?

\_\_\_\_\_

Please list any complications during the pregnancy, labour, or delivery:

\_\_\_\_\_

Did you experience any emotional stress during the pregnancy?

### **FEEDING HISTORY AND CURRENT DIET**

\_\_\_\_\_

Was your child breast fed? If yes, for how many months?

\_\_\_\_\_

Was your child formula fed? If yes, what type? For how long?

\_\_\_\_\_

Introduction of solids/cow's milk- please note dates and types of foods introduced:

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Please list known food sensitivities:

Food Preferences:

Typical Daily Diet

Breakfast	
Lunch	
Dinner	
Snacks	
Beverages	

**SLEEP HABITS**

What are your child's current sleep habits?

Please list any recurrent dreams and/or nightmares:

Does your child experience any bedwetting? If yes, for how long?

**DEVELOPMENT**

Please list any concerns about your child's mental or physical development:

**SOCIAL/PSYCHOLOGICAL**

Does your child currently attend daycare or school?

Please list any learning disabilities or concerns with school performance:

Does your child enjoy playing with other children?

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How much time each week is spent with friends and peers?

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What extracurricular activities is your child involved in?

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How would you describe your child's personality?

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What are their activity preferences? How do they like to spend their time?

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How much time is spent each day watching television and playing video games?

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Is your child involved in any form of exercise? If so, what and how often?

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What does your family do together for fun?

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How would you describe the level of stress in your household?

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**OTHER HEALTH CONCERNS/ADDITIONAL COMMENTS**

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