

**NATUROPATHIC PEDIATRIC INTAKE FORM**

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Child's name: \_\_\_\_\_ Child's Age: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Child's grade level: \_\_\_\_\_ Sex: M F  
Who is filling out this form? (name and relationship):  
\_\_\_\_\_

How did you learn about our clinic?  
\_\_\_\_\_

Who does the child live with?  
\_\_\_\_\_

\*\* Naturopathic and preventative health care is only possible when the doctor has a complete picture for the client physically, mentally and emotionally. Therefore, please take the time to thoroughly complete this health questionnaire.\*\*

CONTACT INFORMATION

Name and relation to child:  
\_\_\_\_\_

Address:  
\_\_\_\_\_  
\_\_\_\_\_

Phone number: (home) \_\_\_\_\_ (work) \_\_\_\_\_  
(cell) \_\_\_\_\_ (email) \_\_\_\_\_  
\_\_\_\_\_

Name and relation to child:  
\_\_\_\_\_

Address:  
\_\_\_\_\_  
\_\_\_\_\_

Phone number: (home) \_\_\_\_\_ (work) \_\_\_\_\_  
(cell) \_\_\_\_\_

Please list any additional health care providers with their designation (pediatrician, family physician etc.) and contact information:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PRIMARY HEALTH CONCERNS

In your opinion, what are your child's most important health concerns?

1. \_\_\_\_\_ 2. \_\_\_\_\_  
— —

3. \_\_\_\_\_

5. \_\_\_\_\_

4. \_\_\_\_\_

6. \_\_\_\_\_

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How did these conditions develop? Include date of onset, development and duration of symptoms, treatment and response to treatment, and changes in condition. Can you identify any traumatic events (life trauma, surgery, drug reactions) as having caused or aggravated your child's health concerns?

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### MEDICAL HISTORY

How would you describe your child's general state of health (excellent, good, fair or poor)?

Please indicate any surgeries, hospitalizations, injuries or serious conditions your child has experienced with approximate dates.

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Current medications or supplements:

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Past medications or supplements:

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How many times has your child had antibiotics? \_\_\_\_\_

Does your child have any allergies (medications, environmental)?

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Has your child been to see the dentist? [ ] yes [ ] no

Describe any dental work done: \_\_\_\_\_

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Describe your child's daily oral hygiene practice: \_\_\_\_\_

\_\_\_\_\_

Has your child had their vision checked?  yes  no

Describe any vision problems: \_\_\_\_\_

\_\_\_\_\_

Bowel/Urinary Habits:

Frequency of stool \_\_\_\_\_ times per day, \_\_\_\_\_ times per week

Does your child experience any pain when passing stool? \_\_\_\_\_

\_\_\_\_\_

Do any of your child's bowel habits concern you? \_\_\_\_\_

\_\_\_\_\_

Are there any urinary symptoms you are concerned about? \_\_\_\_\_

\_\_\_\_\_

Has your child ever experienced any of the following conditions? If you are unsure of any of the terminology please put a question mark beside the word.

Allergies- seasonal	<input type="checkbox"/> yes <input type="checkbox"/> no	Frequent colds	<input type="checkbox"/> yes <input type="checkbox"/>
Diarrhea	<input type="checkbox"/> yes <input type="checkbox"/>	no	
no		Cancer	<input type="checkbox"/> yes <input type="checkbox"/> no
Allergies-environmental	<input type="checkbox"/> yes <input type="checkbox"/>	Hay fever	<input type="checkbox"/> yes <input type="checkbox"/> no
no		Chicken pox	<input type="checkbox"/> yes <input type="checkbox"/> no
Difficulty concentrating	<input type="checkbox"/> yes <input type="checkbox"/>	Head lice	<input type="checkbox"/> yes <input type="checkbox"/> no
no		Chronic Bedwetting	<input type="checkbox"/> yes <input type="checkbox"/> no
Appendicitis	<input type="checkbox"/> yes <input type="checkbox"/> no	Hyperactivity	<input type="checkbox"/> yes <input type="checkbox"/> no
Difficulty sleeping	<input type="checkbox"/> yes <input type="checkbox"/>	Chronic Bleeding noses	<input type="checkbox"/> yes <input type="checkbox"/>
no		no	
Atopic Dermatitis	<input type="checkbox"/> yes <input type="checkbox"/>	Impetigo	<input type="checkbox"/> yes <input type="checkbox"/> no
no		Chronic Bruising	<input type="checkbox"/> yes <input type="checkbox"/>
Ear infection	<input type="checkbox"/> yes <input type="checkbox"/> no	no	
Asthma	<input type="checkbox"/> yes <input type="checkbox"/>	Measles	<input type="checkbox"/> yes <input type="checkbox"/> no
no		Cold sores	<input type="checkbox"/> yes <input type="checkbox"/> no
Eczema	<input type="checkbox"/> yes <input type="checkbox"/>	Meningitis	<input type="checkbox"/> yes <input type="checkbox"/> no
no		Colic	<input type="checkbox"/> yes <input type="checkbox"/> no
Bronchitis	<input type="checkbox"/> yes <input type="checkbox"/> no		

Mumps	<input type="checkbox"/> yes <input type="checkbox"/>	Croup	<input type="checkbox"/> yes <input type="checkbox"/> no
no		Thrush	<input type="checkbox"/> yes <input type="checkbox"/>
Conjunctivitis(pink eye)	<input type="checkbox"/> yes <input type="checkbox"/>	no	
no		Diabetes	<input type="checkbox"/> yes <input type="checkbox"/>
Pneumonia	<input type="checkbox"/> yes <input type="checkbox"/> no	no	
Constipation	<input type="checkbox"/> yes <input type="checkbox"/> no	Tonsillitis	<input type="checkbox"/> yes <input type="checkbox"/> no
Sinusitis	<input type="checkbox"/> yes <input type="checkbox"/> no	Diaper rash	<input type="checkbox"/> yes <input type="checkbox"/> no
Convulsions	<input type="checkbox"/> yes <input type="checkbox"/> no	Urinary tract infection	<input type="checkbox"/> yes <input type="checkbox"/> no
Skin rash	<input type="checkbox"/> yes <input type="checkbox"/> no	Seizures	<input type="checkbox"/> yes <input type="checkbox"/>
Cradle Cap	<input type="checkbox"/> yes <input type="checkbox"/> no	no	
Strep throat	<input type="checkbox"/> yes <input type="checkbox"/> no	Headaches	<input type="checkbox"/> yes <input type="checkbox"/> no

VACCINATION HISTORY

<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Hemophilus B	<input type="checkbox"/> Flu
<input type="checkbox"/> DPT or DT – (Diphtheria, Pertussis, Tetanus)	<input type="checkbox"/> MMR – (Measles, Mumps, Rubella)	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Polio	<input type="checkbox"/> Tetanus	
	<input type="checkbox"/> Chicken pox	

Please indicate if your child experienced any adverse reactions to any vaccination:

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FAMILY HISTORY

Have any close relatives had any of the following conditions:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Seizures
<input type="checkbox"/> Anemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Birth defects	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Depression
<input type="checkbox"/> Cancer	<input type="checkbox"/> Mental illness
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Juvenile Arthritis	<input type="checkbox"/> Eczema
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Hay fever

Do either of the parents have any history of chronic illness?

LIFESTYLE

What time does your child go to bed? \_\_\_\_\_ Wake up?

Does your child take naps? \_\_\_\_\_ When?

Do they have any trouble falling asleep?

Do they sleep straight through the night?

Do they wake up looking/acting refreshed?

Do they have any recurring dreams or nightmares? \_\_\_\_\_

Please write a short description of your child as he/she is currently. Include strengths, weaknesses and major personality traits:

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Is your child currently in school, daycare, at home? \_\_\_\_\_

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How would you describe your child's behaviour in school/ daycare? \_\_\_\_\_

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Does this differ greatly from behaviour at home? \_\_\_\_\_

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What makes your child angry? \_\_\_\_\_

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Do they have any difficulties expressing anger? \_\_\_\_\_

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Do they experience uncontrollable rage? \_\_\_\_\_

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What makes your child sad? \_\_\_\_\_

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Does he/she cry when sad? \_\_\_\_\_

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List major experiences of grief or loss in your child's life? \_\_\_\_\_

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What fears does your child have? \_\_\_\_\_

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How does your child react when afraid? \_\_\_\_\_  
\_\_\_\_\_

What is the emotional climate in the child's home? \_\_\_\_\_  
\_\_\_\_\_

Does anyone in the household smoke? \_\_\_\_\_  
\_\_\_\_\_

Does the child exercise regularly? How much and what form of activity? \_\_\_\_\_  
\_\_\_\_\_

How many hours of television does your child watch each day? \_\_\_\_\_  
\_\_\_\_\_

PRE-NATAL HEALTH AND BIRTH HISTORY

How old was the mother at the time of the child's birth? \_\_\_\_\_  
Number of previous pregnancies the mother carried to term? \_\_\_\_\_  
Number of previous pregnancies not carried to term? \_\_\_\_\_

	Excellent	Fair	Good	Poor	Unknown
How was the health of the mother at time of conception?					
How was the health of the father at time of conception?					
How was the health of the mother during the pregnancy?					
How was the emotional state of the mother during pregnancy?					
How was the mother's diet during pregnancy?					

Did the mother receive medical care during pregnancy? \_\_\_\_\_  
\_\_\_\_\_

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

- alcohol, cigarettes or recreational drugs \_\_\_\_\_
- prescription drugs or over the counter medications (eg. Tylenol) \_\_\_\_\_  
\_\_\_\_\_
- supplements or vitamins ? \_\_\_\_\_  
\_\_\_\_\_

Were there any interventions used during the pregnancy? (eg. ultrasound or amniocentesis) \_\_\_\_\_  
\_\_\_\_\_

Were there any interventions used or complications during the delivery? (eg. Epidural, forceps, c-section, induction) \_\_\_\_\_  
\_\_\_\_\_

Weight of infant at birth: \_\_\_\_\_  
Term length of pregnancy:  
 pre-term (37 weeks or less): \_\_\_\_\_ weeks  
 full-term (38-42 weeks): \_\_\_\_\_ weeks  
 post-term (42 weeks or more): \_\_\_\_\_ weeks

Did the infant experience any of the following conditions during or following the birth?  
 injuries during the birth:

\_\_\_\_\_

birth defects:

\_\_\_\_\_

jaundice:

\_\_\_\_\_

infections:

\_\_\_\_\_

### DIET HISTORY

Breast fed? \_\_\_\_\_ How long? \_\_\_\_\_

Approximate feeding schedule?

\_\_\_\_\_

Formula? \_\_\_\_\_ How long? \_\_\_\_\_ Combined with breast milk?

\_\_\_\_\_

What type of formula was used? (milk, soy, other) \_\_\_\_\_

At what age was solid food first introduced?

\_\_\_\_\_

What types of food were introduced and in what order? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Did your child have any reaction to the food being introduced? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child have any current food allergies? \_\_\_\_\_

\_\_\_\_\_

Does your child have any dietary restrictions? (eg. Religious, vegetarian, vegan)

\_\_\_\_\_

What is a typical day's diet for your child?

Breakfast:

\_\_\_\_\_

Lunch:

\_\_\_\_\_

Dinner:

\_\_\_\_\_

Snacks:

\_\_\_\_\_

Beverages:

\_\_\_\_\_

List any foods that your child seems to crave, regardless of their nutritional value (includes sweets, chocolate, salty, sour, bread, rich/fatty foods etc.)

Is your child thirsty?  yes  no Amount of liquid child drinks each day? \_\_\_\_\_

Amount of plain water: \_\_\_\_\_

What temperature of liquid does your child prefer to drink?  hot  cold  room temp

Are you satisfied with your child's diet the way that it is now? Why or why not?

What is the approximate weight of your child? \_\_\_\_\_

Has there been any recent weight gain or weight loss? \_\_\_\_\_