ROOTED...

NATUROPATHIC PEDIATRIC INTAKE FORM – Ages 0-5

Child's name: _____

Gender: _____ Date of birth: _____ Age: _____

Parents are (circle one): Married Separated Divorced Common law
Other: _____

Parent's Names & Contact Information

1. _____ Phone Number: _____

Address: _____

2. _____ Phone Number: _____

Address: _____

What number may we leave messages at? _____
Email address_____
Would you like to be included in our e-mail list? yes no
Emergency contact: _____ Phone: _____
Has any other family member already been a client of this clinic?
_____

How did you find out about us? (please check all that apply):
❑Yellow Pages ❑Friend: Whom should we thank? _____
❑Website ❑Professional Referral: Whom should we thank? _____
❑OAND ❑Facebook ❑Other _____

Reason for office visit	How long has this been going on?
1.	
2.	
3.	

93 Bell Farm Rd., Unit 103 Barrie Ontario L4M 5G1 T: 705-792-6717 F. 866-735-8688 www.rootedinhealth.ca

Health Care Providers:
Family Doctor: Name: _____ Phone number: _____
Other Providers: Name: _____ Phone number: _____
Name: _____ Phone number: _____

List any surgeries or major illnesses (with dates):

List any current medications and/or supplements (*please bring with you to first appointment):

List any past medications and/or supplements (include dates):

If your child has taken antibiotics, how many times? _____

Any known allergies to foods, medication, supplements, animals or environment?

FAMILY MEDICAL HISTORY

	Age/Age at death	General health (excellent, good, poor)	Health conditions
Mother/Father			
Mother/Father			
Sibling 1			
Sibling 2			
Maternal Grandfather			
Maternal Grandmother			
Paternal Grandfather			
Paternal Grandmother			
Other			

* Parents of same sex families, please indicate the name of each parent listed.

Was your child adopted? ❑ Yes ❑ No If yes, at what age: _____

HEALTH HISTORY Please check all that apply (circle c=current or p=past):

❑ Cradle cap	c	p	❑ Eczema	c	p
❑ Diarrhea	c	p	❑ Constipation	c	p
❑ Asthma	c	p	❑ Anemia	c	p
❑ Chronic sniffles/stuffiness	c	p	❑ Diaper rash	c	p
❑ Nightmares	c	p	❑ Bedwetting	c	p
❑ Allergies	c	p	❑ Fears/phobias	c	p
❑ Colds	c	p	❑ Ear infection	c	p
❑ Lice	c	p	❑ Conjunctivitis (Pink eye)	c	p
❑ Poor teeth	c	p	❑ High fever	c	p
❑ Hyperactivity	c	p	❑ Extreme shyness	c	p
❑ Chicken pox	c	p	❑ Measles	c	p
❑ Fifths disease	c	p	❑ Erythema Infectiosum	c	p
❑ Warts	c	p	❑ Strep throat	c	p
❑ Colic	c	p	❑ Impetigo	c	p
❑ Finicky eater/ Poor appetite	c	p	❑ Hearing/vision problems	c	p
❑ Thrush	c	p	❑ Mumps	c	p
❑ Tantrums	c	p	❑ Diagnosis of ADD/ADHD	c	p
❑ Stomach aches	c	p	❑ Other:		

PRENATAL HISTORY

What age was mother at child's conception? _____ Father's age at conception?_____

Parents health at conception (E=excellent, G=good, P= poor) M: _____ F: _____

Was your child conceived naturally? ❑ Yes ❑ No

Was there any difficulty conceiving this child? ❑Yes ❑ No

Any fertility interventions? ❑ Yes ❑ No If yes, explain:

Any illnesses, medications or exposures to toxins during pregnancy?

EARLY CHILDHOOD HISTORY

Child's gestational age at birth:

Pre-term (<37 wks): wks	Full-term (38-42): wks
Post-term (>42): wks	

Were any of the following used during the birth? Please circle

Induced labour	Forceps	Vacuum extraction	Epidural/anesthesia
Episiotomy	Oxytocin/Pitocin	Pain Medication	C-section
Other:			

Vaccinations: Did your child receive vaccinations? ❑ Yes ❑ No
Describe reactions to vaccinations, if any:

Does your child have any unusual habits?

Does your child have any fears?

How is your child's behaviour at home?

Is your child in: ❑ school ❑ daycare ❑ homecare ❑ otherWhat grade level?

General school/daycare behaviour and performance:

Has your child been diagnosed with any learning disabilities?

Does your child make friends easily?

Child's interests and favourite activities?

How many hours/week does your child:

❑ Play on the computer or video games _____ ❑ Watch TV_____

❑ Read (not for school) _____ ❑ Exercise _____

Please describe your child's personality:

NUTRITION

Was the child breast-fed? ❑ Yes ❑ No If "yes", until what age?_____

If "no", what type of formula or other liquid was used?_____

At what age were solid foods introduced?_____

Describe any noticeable reactions to foods introduced (rashes, changes in sleeping habits)

Describe any dietary restrictions (food intolerances/ allergies, religious, vegetarian, vegan, etc.)

Describe any food cravings:

Describe any food aversions:

List your child's dietary intake for the last 24 hours.

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

What is the source of your household's drinking water?

❑ Well ❑ Tap ❑ Filtered ❑ Distilled ❑ Bottled spring ❑ Reverse osmosis

ENVIRONMENT

Is your child sensitive to any of the following? Please circle

Cold	Heat	Wind	Draft	Smell
Height	Sunlight	Music	Wool	Small spaces
Other:				

SLEEP

Describe any issues your child has regarding bedtime, naps, falling asleep, etc:

ANYTHING ELSE?

Please include any other information that hasn't already been described in these forms that you would like to share with us.