Centre intégratif de santé

Integrative Health Centre

Kadeja Lefebvre, BSc, ND.
63 Westminster Avenue N.
Mtl-West, QC H4X 1Y8

Tel: 514-485-6789
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PEDIATRIC INTAKE FORM

Date:
Name: Age: Date of birth:
Sex: M/F Height:__________________ Weight:

Parent/Guardian:

Name:
Phone number: Home: ______________________Work:
Address:
Email Address:
Who does child live with?

General Practitioner?
Name:
Other health care providers?
Name:
Phone number:

Referred by:

Chief Concern(s) in order of importance:

	Concern	How long?	Prior treatment(s):	Results:
1				
2				
3				
4				
5				

Medical History:

Hospitalization/surgery/serious injuries (date?): tonsils, appendix, fractures, other:

Childhood Illness:

	Yes	No	Comments
Allergies			Environmental Food Other
Chicken pox			
Ear infections (chronic)			Acute Chronic Frequency
Frequent colds			Number per year?
Measles			
Mumps			

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Pneumonia			
Rheumatic fever			
Rubella			
Scarlet fever			
Strep throat			
Tonsillitis			Removed? Y/N

Immunization History - check off immunization received; any reactions

Measles, Mumps, Rubella (MMR) Y/N

Diptheria, Pertussis, Tetanus (DPT) Y/N

Polio Y/N

Influenza Y/N

Smallpox Y/N

Hepatitis Y/N
Chicken pox (Varivax) Y/N

Other

Current list of medications and supplements:

Family History:

	Age	Health problems (ex: allergies, asthma, heart dz, high blood pressure, cancer, diabetes, etc)	If deceased, cause of death	Age at death
Mother				
Father				
Sister				
Brother				
Grandparents				
Other				

Child's Symptoms – checkmark if current, P for past symptoms:

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	Diaper rash		Easy bleeding		Cries easily
	Eczema		Bloody nose		Sleep problems
	Diarrhea		Frequent vomiting		Night sweats
	Constipation		Stomach aches		Hair loss
	Cradle cap		Fatigue		Dizzy spells
	Dental caries		Burning of urine		Hearing loss
	Unusual fears		Frequent urination		Cough
	Perspiration		Bed wetting		Appetite change
	Thirst		Blood in urine		Motion sickness
	Discharges		Sore throats		Body/Breath odor
	Growing pains		Wheezing		Nervous

PRENATAL HISTORY

Difficulties and exposures the mother experienced during pregnancy:

Infections (include treatment)			
Emotional trauma	Y/N	Physical trauma	Y/N
Diabetes	Y/N	Nausea/vomiting	Y/N
Thyroid conditions	Y/N	High blood pressure	Y/N
Cigarettes	Y/N	Toxemia	Y/N
Alcohol	Y/N	Bleeding	Y/N
Recreational drugs	Y/N	Medication	Y/N
Supplement(s)	Y/N	Disease and other illnesses	Y/N

Place of birth:

Did you travel during your pregnancy?

Did you work during your pregnancy?

Marital status and stability of the home:

Parents' age at time of conception: Mother
Father

Parents' health at time of conception: Mother - poor, good, excellent
Father – poor, good, excellent

Father's exposure to smoking, alcohol, drugs, toxins, etc…

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BIRTH HISTORY

Premature/full/late	
Weight/Height	
Home/hospital birth	
Any interventions: pain medication(s), epidural, forceps, vacuum, pitocin, other	
Length of labor	
Mother's emotional state at time of birth	
Mother's emotional state post-partum (post partum depression, etc…)	
Any post partum incidents: (breast-feeding, respiratory distress, etc…)	

NEONATAL HISTORY

Birth defects	Y/N	Anemia	Y/N
Birth injuries	Y/N	Infection(s)	Y/N
Jaundice	Y/N	Rashes	Y/N
Weight gain	Y/N	Colic	Y/N
Respiratory distress	Y/N	Seizures	Y/N
Poor feeding	Y/N		

FEEDING HISTORY

Breast-fed:

- How long?______________

Formula used:

- When was formula used?______________________________
- Type of formula used – milk, soy?______________________

Introduction of solid foods:

- What was introduced first and when?___________________________
- When was cows milk introduced?______________________________
- Food exclusions from child's diet?_____________________________
- Current diet – picky eater, etc…________________________________

____

____

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GENERAL INFORMATION

Sleeping habits:

- During first year of life:_______________________________
- At present:____
- Any napping?_______________________________________
- Trouble falling asleep or staying awake?_________________
- Bedwetting?____
- Bedtime and waking time:_____________________________

Behavior and emotional history:

- At school - performance, anxiety, separation anxiety:___________________
- At home:____
- Relationship with friends, family, siblings:___________________________
- Potty training:____
- Interests and/or activities they partake in:__________________________
- How often does your child exercise per week:________________________
- Fears:____

At what age was your child first:

Sitting Walking Talking Rolling over First tooth ________________________

Pets in household: ____

Travel outside of Canada:
Any additional comments: ____

This form is included in the doctor/patient confidentiality act. However, any child abuse must be reported.

Diet Journal – **(see attached next page!)**

You may print up this page, fill it in by hand, and bring it with you to your child's first appointment.

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The purpose of this daily record is to help you keep close watch over what your child is eating, and help you discover which, if any, foods or beverages may be causing or contributing to his/her symptoms. Use this as a tool for to become more in tune with their dietary habits. It is very important that the information your record in this diary be as accurate and as correct as possible. The more honest you are the more you will learn about your child and the easier it will be to identify problem foods.

1. The following is to be done for 5 days in a row.
2. Write down everything that enters their mouth, including water, snacks, soft drinks, and so on.
3. List the contents found inside mixed dishes and foods. It is not enough to write down "a ham sandwich". You should also write down the kind of bread, spread, and dressing (i.e.: ham sandwich – whole wheat bread, butter, mustard).
4. Whenever you make an entry in the diary, ask yourself, "Have I given myself and my Naturopathic Doctor enough information about what is in this food?"

DATE	***BREAKFAST***	***LUNCH***	***DINNER***	***SNACK/ BEVERAGES***	***Digestive, urinary, skin complaints***	***Overall Energy Mood***
DAY 1						
DAY 2						
DAY 3						
DAY 4						
DAY 5						