Valley Naturopathic Clinic
139 Union St., Berwick, N.S.
B0P 1E0 (902) 538-8733

Pediatric Intake

Date: ____________

Thank you for taking the time to fill out this form. The information is very important in the assessment of your child.

Patients Name ____________ Age: ______ Sex: _____ Birthdate: ________
Mother's Name: ________________ Phone Number (h)_______ (w)________
Father's Name: ________________ Phone Number (h)_______ (w)________
Home Address: ____
How did you hear about this Clinic? ______________________________
____

Name of Physician, Clinic or Hospital where your child's records are kept:
Name: ______________________________ Phone: ______________
Address: ____
____

Reason for referral or presenting problems: ___________________________
____
____

MEDICATIONS

	Now	Past		Now	Past
Aspirin			Antibiotics		
Tylenol			Anti-histamine		
Decongestant			Other		
Ventolin/Pulmocort			Allergies to medicines		

Supplements ______________________________________

MEDICAL HISTORY

Childhood Illnesses (Please check those which you child has experienced)

___ Chicken Pox ___ Scarlet fever ___ Tonsillitis, approx. no ________
___ Measles ___ Pneumonia ___ Ear Infections no. __________
___ Mumps ___ Frequent Colds ___ Other: (Please list)
___ Rubella ___ Rheumatic fever

Has your child had any other following tests?

	When	Where	Results
Psychological Evaluation			
Electroencephalogram			
Hearing			
Speech/language			

Injuries/ Surgeries /Hospitalizations(Please list): ___________________________
____

IMMUNIZATIONS

___ Measles ___ Polio ___ MMR ___ Smallpox
___ Diptheria ___ Mumps ___ DPT ___ Tetanus
___ Influenza ___ Other (list)______________________________
Reactions to vaccination? ____________________________________

FAMILY HISTORY

___ Heart Disease
___ Hypertension
___ Cancer
___ Diabetes
___ Arthritis
___ Allergies
___ Birth Defects
___ Tuberculosis
___ Mental Illness

Previous pregnancies by natural mother, miscarriages or complications: ____________________
____
____

Mother's age at child's birth? _________
Mother's Health during pregnancy?
____ Bleeding
____ Illness
____ Cigarettes, alcohol, drug consumption
____ Thyroid Problems
____ Physical or emotional trauma
____ Medications
____ Diabetes
____ Nausea
____ Hypertension

BIRTH HISTORY

Term: ____ Full ____ Premature ____ Later Weight at Birth ______________
Length of Labour: __________ Complications? ________________________________

Has your baby had any of the following problems
____ Jaundice
____ Rashes
____ Cerebral Palsy
____ Seizures
____ Diarrhea
____ Colic
____ Allergies
____ Birth injuries (other)- Explain
____ Birth Defects
____ Fever
____ Blue baby

Child's sleeping patterns (First year): ____
Food intolerances (if any): ____
Feeding: Breast Fed? _____ How Long? _____ Formula? _____ Milk/Soy _____
Age began solid food? __________________
Age began: Sitting: _____ Crawling: _____ Walking: _____ First words: _____

Symptoms: (Mark **Y**- If current, **P** for past symptoms)

____ Hives
____ Eczema
____ Bleeding gums
____ Nose bleeds
____ Acne
____ High fever
____ Chronic rash
____ Hearing loss
____ Diarrhea
____ Sore throats
____ Frequent headaches
____ Frequent colds
____ Wheezing
____ Cough
____ Burning of urine
____ Frequent urination
____ Heart murmur
____ Vomiting spells
____ Anemia
____ Stomach aches
____ Jaundice
____ Easy bruising
____ Flat feet
____ Constipation
____ Gas
____ Bleeding tendency
____ Joint pains
____ Dizzy spells
____ Bloody urine
____ Cries easily
____ Sleep problems
____ Nervous
____ Night sweats
____ Sensitive to light
____ Body/Breath Odor
____ Motion/Car sickness
____ No appetite
____ Nightmares
____ Canker sores
____ Unusual fears
____ Excessive fatigue
____ Hair loss

Diet

Please describe your child's typical diet? ____
____
____
____
____