PRECISIONHEALTH

Naturopathic Pediatric Intake Form

Dr. Nadia Lamanna ND., BSc (Hons.)

To be completed by the parent/guardian. An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future please let us know. All information gathered for treatments is confidential except as required or allowed by law to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: ______________________ Age: ________ DOB: __________ Gender: ______
Address: ____
Number Street Suite City Province Postal Code
Mother's Name: ______________________ Father's Name: ______________________
Tel (home): ( )____________ Tel (work): ( )____________ Cell: ( ) ____________
Physician's Name: ______________________ Tel: ( ) ____________
Physician's Address: ____
Number Street Suite City Province Postal Code
If Emergency Notify: ______________ Relationship: __________ Tel: ( ) __________
Date of last visit to physician or health practitioner: ______________________
Email: ____
How did you hear about us? ____

What are your child's chief health concern(s)? ____

____

Medications: (please check)

	Now	Past		Now	Past
Aspirin	______	______	Antibiotics	______	______
Tylenol	______	______	Anti-histamine	______	______
Ibuprofin	______	______	Decongestant	______	______

Please list any other prescriptions/over the counter/supplements currently taking: ______________________

____

How many times and for what reasons has your child been treated with antibiotics? ______________________

____

Medical History:

Please check all that apply:

- ❑ Measles
- ❑ Mumps
- ❑ Rubella
- ❑ Scarlet Fever
- ❑ Strep Throat
- ❑ Pneumonia
- ❑ Frequent colds
- ❑ Chickenpox
- ❑ Tonsilitis (#) ________
- ❑ Ear Infections (#) ________
- ❑ Rheumatic Fever
- ❑ Other ______________________________

Has your child had any of the following tests?

	When	Where	Results
Electroencephalogram	________	________	________
Psychological Evaluation	________	________	________
Hearing	________	________	________
Speech/Language	________	________	________

Injuries/Surgeries/Hospitalizations (please list): ____

____

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Immunizations

Adverse Reaction

- ❑ Measles, Mumps Rubella (MMR) ______________________
- ❑ Diptheria, Pertussis, Tetanus (DPT) ______________________
- ❑ Polio (IPV, DPTP) ______________________
- ❑ Influenza ______________________
- ❑ Hepatitis B (HepB) ______________________
- ❑ Hepatitis A (HepA) ______________________
- ❑ Haemophilus Influenza B (HIB) ______________________
- ❑ Rotavirus (RV) ______________________
- ❑ Pneumococcal (PCV) ______________________
- ❑ Varicella (chicken pox) ______________________
- ❑ Gardasil (HPV) (given at ages 9-13) ______________________
- ❑ Other ______________________

Please circle if you child is currently experiencing (“C”) or has experienced in the past (“P”) any of the following:

P C	Asthma	P C	Anemia	P C	Fatigue	P C	Acne
P C	Cough/wheeze	P C	Insomnia	P C	Frequent Infections	P C	Eczema
P C	Dizzy spells	P C	Earache	P C	Cradle Cap	P C	Colic
P C	Headaches	P C	Jaundice	P C	Hyperactivity	P C	Thrush
P C	Nosebleeds	P C	Moodiness	P C	Constipation	P C	Warts
P C	Epilepsy/Seizure	P C	Unusual Fear	P C	Learning Disorder	P C	Diarrhea
P C	High Fever	P C	Depression	P C	Heart Murmur	P C	Vomiting
P C	Bed Wetting	P C	Skin Rash	P C	Stomach aches	P C	Gas
P C	Bloody urine	P C	Nightmares	P C	No Appetite	P C	Nervous

Family History

Please check relevant areas for blood relatives:

❑ Asthma	❑ Arthritis	❑ Bleeding problems	❑ Cancer	❑ Diabetes
❑ Eczema	❑ Epilepsy	❑ Eating Disorder	❑ Gout	❑ Allergies
❑ Heart problem	❑ Kidney problem	❑ High blood pressure	❑ Obesity	❑ Stroke
❑ Mental disorder	❑ Tuberculosis	❑ Thyroid problem	❑ Substance abuse	

Prenatal History

Mothers age at time of birth ______________ Fathers age at time of birth ______________

Mothers health during pregnancy: *please check all that apply*

❑ Stress	❑ Physical/Emotional Trauma	❑ Depression
❑ Bleeding	❑ Alcohol/Drugs/Tobacco	❑ Travel
❑ Diabetes	❑ Thyroid condition	❑ High blood pressure
❑ Nausea	❑ Weight gain (how much) _________	❑ Xrays/other tests ______________________

Over the counter or prescription drugs during pregnancy: ______________________

Supplements during pregnancy: ______________________

Were there any problems conceiving? ______________________

Did mom have any food cravings? ______________________

Were there any foods that mom could not tolerate? ______________________

Birth History

❑ Vaginal Birth ❑ C-Section (reason)______________________

Term: ❑ Full ❑ Premature ❑ Late

Labour: ❑ Spontaneous ❑ Induced

Complications at birth: ______________________

Interventions at birth (e.g. anesthesia, epidural, episiotomy, forceps, vacuum, other) ______________________

____

Birth weight: ______________________ Birth length: ______________________

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Solid Food Introduction:

Age	Food(s)	Reactions (if any)

General Information

❑ Breast Fed For how long? ____________________

❑ Formula Fed What kind? ____________________

Is the child currently exposed to any of the following:

❑ Cigarettes ❑ Chemicals ❑ Molds ❑ New Carpet

Food/Environmental/Pet Allergies?____________________

Describe your child's Temperament ____________________

____

Child's favorite activities/hobbies ____________________

____

Is there any additional information you would like to add?

____

____

____

____

Signature ____________________ Date ____________________

Thank you for taking the time to complete this form. All information is confidential and will not be released for legal or medical purposes without your consent.