NC

Dr. Nadine Cyr N.D. Naturopathic Doctor

Pediatric Intake *(Birth to 12 years)*

Patient's Name: _____ Age: _____ M / F Date of Birth: _____
Mother's Name: _____ Father's Name: _____
Phone # _____ email: _____
Referred by: _____ Today's Date: _____

Primary Contact: _____ Relation: _____ Lives with child Y / N
Phone # _____ email: _____
Secondary Contact: _____ Relation: _____ Lives with child Y / N
Phone # _____ email: _____

Presenting Health Concerns:

1.	4.
2.	5.
3.	6.

Childhood Illnesses – Please Circle or Check Off

Allergies	Asthma	Bladder Infections	Bronchitis	Chicken Pox	Croup
Ear Infections	Eczema	Frequent Cold/Flu	Pneumonia	Reflux	Strep throat

Other Illnesses: _____

Has your child had any of the following tests? **Results:**

_____ Electroencephalogram _____
_____ Psychological Evaluation _____
_____ Hearing _____
_____ Speech/Language _____
_____ GI Function Test _____
_____ Psychoeducational Assessment _____

Surgeries/Hospitalizations (please list):

_____

_____

Child's Medication History:

_____ Antacids (Losec, Zantac) _____ Anti-Histamines _____ Hydrocortisone Creams
_____ Antibiotics # of times: _____ Bronchodilators/Puffers _____ Tylenol / Advil
_____ Seizure medication _____ ADD medication

Other Medications: _____

Immunizations: On schedule ___ Delayed _____

DTaP-IPV-Hib	Pneumo C-13	Rot 1	Men CC	MMR	Var	MMRV	HB	HPV	Pneumo-P23	Inf

Other Vaccines: _____
Tylenol given before and/or after vaccines? Yes No
Adverse reactions to any vaccine? _____

Family History

Number of siblings: ____ Birth order of this child: _____
Please indicate if any family member (parents, siblings, grandparents) has experienced any of the following:

	Relative		Relative
ADD/ADHD		Diabetes I or II	
Alcoholism		Heart Disease	
Allergies		Thyroid disorders	
Anxiety / Depression		Ulcerative Colitis/	
Asthma		Crohn's	
Autism		Multiple Sclerosis	
Cancer		Other:	

Prenatal Health History

Health of Parents at Time of Conception:

Mother: Poor _____Fair _____Good _____Excellent _____*Unknown* _____
Father: Poor _____Fair _____Good _____Excellent _____*Unknown* _____
Mother's age at child's birth _____Previous pregnancies (#) _____ Miscarriages (#) _____
Conception History: IUI ___ IVF ____ Egg Donor ___ Sperm Donor____

Mother's Health during pregnancy:

Bleeding	Physical or Emotional Trauma	Diabetes	Nausea / vomiting	Hypertension
Anemia	Allergies	Thyroid imbalances	Cigarettes, alcohol, drug consumption	Recurrent Infections

Mother's diet during pregnancy: Poor ____Fair _____Good _____Excellent _____*Unknown* _____
Medications or Supplements taken during pregnancy: _____

Birth History

Premature _____(wks) Full Term _____ Late _____(wks) Induced Labor Y / N Birth weight: _____
Epidural: Y / N Length of Labor: _____(hrs) Antibiotics: Y / N
Delivery: Vaginal _____C-Section _____Forceps _____Vacuum _____
Birth Injuries: _____NICU:Y / N Jaundice: Y / N
Complications: _____

Mother's Health Post-Partum:

Depression _____ non-medicated _____ medicated _____ Medication used: _____
Excessive bleeding ____ Infection _____ Fatigue _____ Stress _____

Eating Patterns:

Breast Fed Y / N How long? _____ Formula Y / N (cow's milk / soy / other) Intolerances to formula Y / N
Did your child experience colic? Y / N Reflux? Y / N Mild _____Moderate _____Severe _____
Solid Food Introduction: _____months First Food: _____Adverse reactions: _____
Food Intolerances (if known): _____
Food Allergies (anaphylactic): _____

Milestones:

Sitting _____(mths) Crawling _____(mths) Walking _____(mths) First Words _____(mths)

Sleep Patterns:

1st year: good / fair / poor
Current: good / fair / poor
Average Bedtime _____ pm Sleeps with night light Y / N
Problems falling asleep Y / N Problems staying asleep Y / N
Sound sleeper Y / N Light sleeper Y / N Restless sleeper Y / N

Mark (C) for Current and (P) for Past symptoms:

Eczema	Constipation	ADD/ADHD	Frequent colds	Concussion
Dry skin	Diarrhea	Autism	Strep Throat	Fatigue
Hives	Stomach pain, cramps	Unusual fears	Ear Infections	Broken bones
Chronic Rash	No appetite	Night terrors	Tubes	Low muscle tone
Allergies	Vomiting spells	Bed wetting	High Fevers	Teeth grinding
Asthma	Gas	Cries easily	Chronic Cough	Sensitive to sounds
Chronic congestion	Parasites	Seizures	Bronchitis	Anemia
Nosebleeds	Cavities	Leg pains	Frequent urination	Headaches
Bruises easily	Weight loss	Tics	Bladder infection	Mood swings

Place a check mark next to the characteristics that best describe your child:

Prone to eye and/or ear discharge	Eyes are sensitive to light	Sweats from feet
Prefers sweet foods	Skin is slow to heal	Sweats from head when sleeping
Prefers salty foods	Cries easily	Prefers cold drinks and food
Prefers warm drinks and food	Sensitivity to odours	Prefers hot weather/summer
Prefers cold weather/winter	Wants to be consoled when upset	Prefers to be alone when upset
Is very self-confident	Is shy, reserved	Has experienced physical trauma
Has experienced emotional trauma	Easily adapts to new situations	Does not like change, new situations
Is generally happy	Is be angry or frustrated often	Loves to play outdoors
Loves animals, is very kind to them	Has a fear of animals	Is adventurous, fearless
Is generally fearful	Loves music and/or dance	Prefers to play alone
Prefers to play with friends	Makes friends easily	Was a late walker or talker
Skin is sensitive to fabrics	Is sensitive to noise	Is a picky eater

School Concerns:

_____

_____

_____