Dr. Michelle Mackay Patel, ND
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NATUROPATHIC PEDIATRIC INTAKE FORM (Birth to 12 years)

PERSONAL INFORMATION:

Child's Given Name(s): ________________________ Last Name: ________________________
Date of Birth (mm/dd/yy): _____/_____/_____ Age: ________ Gender: MALE / FEMALE
Current Height/Length: ____________ Current Weight: ____________

1) Name of Primary Caregiver: ______________________________Relationship to Child: ________
Address: ______________________________ City: ________________ Province: ________
Postal Code: ____________ Email: ______________________________
Phone # (H): ________________ (Cell): ____________________ (W): ________________
2) Name: ______________________________ Relationship to Child: ________________
Address: ______________________________ City: ________________ Province: ________
Postal Code: ____________ Email: ______________________________
Phone # (H): ________________ (Cell): ____________________ (W): ________________

Remind me of appointments by phone? (Please circle) YES / NO

Child's Primary Care Provider (ie. Pediatrician, Medical Doctor): ______________________________
Contact Information: ______________________________
Please list other health care professional the child is currently working with:
Practitioner Name: ________________ Practitioner Type: ______________ Phone: __________
Practitioner Name: ________________ Practitioner Type: ______________ Phone: __________
Practitioner Name: ________________ Practitioner Type: ______________ Phone: __________

HEALTH INFORMATION

Child's current **health concerns**, listed in order of preference:
1) ______________________________ 3) ______________________________
2) ______________________________ 4) ______________________________

How would you rate your child's **overall health**? Poor Fair Average Good Excellent
How would you rate your child's **overall energy**? Poor Fair Average Good Excellent

IMMUNIZATION HISTORY (please check)

Vaccine	Date	Adverse Reactions (e.g. fever, nausea, vomiting, seizures, behaviour changes,etc.)
MMR (measles, mumps, rubella)		
Polio		
DPT (diphtheria, pertussis, tetanus)		

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Influenza (Flu)		
Smallpox		
Haemophilus influenza B		
Hepatitis B		
Hepatitis A		
Tetanus booster		
Pneumococcal (pneumonia)		
Meningococcal (meningitis)		
Varicella (chicken pox)		
Rotavirus		
Other:		

CHILDHOOD ILLNESSES (please check)

	Date (s)	Comments
Chicken pox		
Measles		
Mumps		
Rubella		
Scarlet fever		
Pneumonia		
Whooping cough		
Rheumatic fever		
Roseola		
Bronchiolitis/Bronchitis		
Strep throat		
Ear infections		
Mononucleosis		
Impetigo		
Other		

Surgeries and Hospitalizations (include dates and details): ______________________________

____

____

MEDICATIONS:

Please list all current medications (prescription and over-the counter):

Medication	Dose/day	How long have you been taking?
1.		
2.		
3.		

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4.		
5.		

Please list all vitamins/minerals, herbs or homeopathics:

Supplement and Brand	Dose/day	How long have you been taking?
1.		
2.		
3.		
4.		
5.		

Approximately how many times has your child been treated with antibiotics? ______________________________________

Has your child ever had an adverse reaction to a medication? Y / N If Yes, please explain: ___________________________

____

ALLERGIES:

Please list all of your child's allergies (medications, seasonal, foods, animals etc.):

____

____

PRENATAL / NATAL HISTORY *(if child was adopted please provide as much information as possible)*

The health of birth parents at conception (please circle):

Mother:	Poor	Fair	Average	Good	Excellent
Father:	Poor	Fair	Average	Good	Excellent

Mother's age at child's birth: ____________________

Number of Children:_____________

Total number of pregnancies (including those that were not full term):_________________

Father's age during pregnancy: ___________

Mother's health during pregnancy? (please circle)

Poor Fair Average Good Excellent

Were any of the following experienced during pregnancy? (please check)

	Comment
Bleeding	
Nausea	
Vomiting	
Cravings	
Physical trauma	
Emotional trauma	
Stress	

Depression	
High Blood Pressure	
Thyroid problems	
Gestational diabetes	
Toxemia	
Illness	
Weight gain (how much?)	
X-rays	
Travel	
Other	

Did Mother use any of the following during pregnancy?

Tobacco How much and how often?______________________________

Alcohol How much and how often?______________________________

Recreational Drugs (please specify): ______________________________

Prescription Medications (please specify): ______________________________

Over the counter medications (please specify): ______________________________

Supplements (please specify): ______________________________

Were there any fertility issues surrounding the child's conception Y/N? (If Yes, please specify): ______________________________

____

Briefly describe Mother's diet during pregnancy (including medications and supplements): ______________________________

____

____

CHILD'S BIRTH HISTORY

Term: (please circle) Full Premature: ____________ wks Overdue: ____________ wks

Weight at birth: _________ Length at birth: _________

Birth: (please check any that apply)

Vaginal birth

C-section

Induction

Epidural

Antibiotics

Vacuum

Forceps

Hospital birth

Home Birth

OB/GYN

Midwife

Doula

Were there any complications with the birth? Y or N Details: ______________________________

____

Did the Mother experience Post-Partum Depression? Y or N Details:______________________________

____

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Did your child have any of the following problems shortly after birth?

Birth abnormality	Fever
Cerebral palsy	Blue baby
Colic	Jaundice
Birth injuries	Rashes
Seizures	Other (explain): ________________

DIET

How was your infant fed:

Breastfed: How long?______________

Formula: Type (please circle): MILK SOY OTHER: ______________________________

Other? ____

What foods were introduced before 6 months? (please also specify approximate month)

____

____

What foods were introduced between 6-12 months?

____

____

Does your child have any food intolerances or allergies? Please list.

____

____

Does your child have any dietary restrictions (religious, vegan/vegetarian, etc.)?

____

____

Describe a typical days diet:

Breakfast ____

Snack____

Lunch ____

Snack ____

Dinner ____

Beverages (including quantity) ____

DEVELOPMENT

Describe your child's health in the **first year**?____

____

Age your child began: Sitting _________ Crawling _______ Walking ________ Talking ________

Describe your child's **sleep** patterns ____

____

How would you describe your child's **temperament**? ____

____

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SOCIAL HISTORY

Parents: Married:________Separated:______ Divorced:______ Single Parent:__________

Child lives with:____

Other's living in the home:____

Mother's Occupation:____ F/T or P/T

Father's Occupation:____ F/T or P/T

Day Care/School

Is the child in: (circle) School Daycare Homecare Other: ________________

On average how much time does the patient spend at day care/school?______________________

Describe your child's behaviour and performance at school (include teacher comments and relationships with other children):

____

____

How many hours per day does the child spend:	HRS
Watching Television	
Reading	
Playing Videogames	
Surfing the Internet	
Playing Outside	
Doing Homework	
Organized Sports/Lessons	

Briefly describe the child's personality and general disposition:______________________________

____

ENVIRONMENT

Describe your living environment (ex: house, apartment, new, old):_________________________

Is the child exposed to any of the following (circle all that apply):

cigarette smoke pets mold chemicals (ex: paint)

How is the child's home heated?

Natural Gas Wood
Oil Other: ____________
Electric

How would you describe the emotional climate of your home?

____

____

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FAMILY HISTORY

Please provide age and health concerns for the following biological family members. If deceased, please indicate the age of death.

Mother:____

Father:____

Siblings: ____

____

Maternal Grandparents:____

____

Paternal Grandparents: ____

____

Please indicate if there is a family history of any of the following:

Condition	Relative	Condition	Relative
Alcoholism		Diabetes	
Allergies		Drug abuse	
Alzheimer’s disease		Heart condition	
Arthritis		High blood pressure	
Asthma		Kidney disease	
Cancer (indicate type)		Osteoporosis	
Depression		Stroke	
Other mental illness		Suicide	
Bleeding disorders		Infertility	
Glaucoma		Thyroid Conditions	

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REVIEW OF SYSTEMS

Please **CHECK** if your child is **currently** experiencing any of the following symptoms **OR** write a **"P"** if they experienced it in the past

GENERAL SYMPTOMS:

- Headache
- Head injury
- High fevers
- Chills
- Night Sweats
- Dizzy spells
- Fainting
- Excessive Fatigue
- Nervousness/Anxiety
- Loss of Weight
- Allergies
- Nightmares
- Sleep problems
- Cries easily
- Unusual fears
- Motion/car sickness

SKIN:

- Change in mole(s)
- Hives / allergic reactions
- Acne / skin eruptions
- Itching (ears, skin, rectum)
- Bruising easily
- Dryness
- Sensitive skin
- Eczema
- Body odor
- Hair loss

EARS/EYES/NOSE/THROAT:

- Tonsillitis
- Sore Throat
- Enlarged Glands
- Ear discharge
- Ear infections
- Mastoiditis
- Hearing loss
- Nose bleeds
- Ear ache
- Nasal Discharge
- Nose bleeds
- Sensitivity to light
- Bad breath odor
- Canker sores
- Bleeding gums

MUSCLE & JOINT:

- Spinal scoliosis
- Muscle weakness
- Joint Pains
- Painful tailbone
- Flat feet

KIDNEYS/REPRODUCTIVE:

- Inability to control urine
- Frequent urination
- Painful urination
- Bedwetting
- Kidney infection
- Bloody urine

CARDIOVASCULAR:

- Heart murmur
- Irregular heart beat
- Irregular Heart Beat
- Bleeding gums
- Anemia

GASTROINTESTINAL:

- Bloating
- Excessive thirst
- Excessive hunger
- Reflux
- No appetite
- Belching
- Gas (flatulence)
- Nausea
- Vomiting Spells
- Stomach Aches
- Abdominal Cramps
- Constipation
- Diarrhea
- Jaundice
- Irritable Bowel syndrome

RESPIRATORY:

- Asthma
- Wheezing
- Cough
- Frequent colds

OTHER:

Is there anything additional that you feel is important that has not been covered above?

____

____

____

Thank you for taking the time to fill out this form.
It will help contribute to a treatment protocol that will better your child's healthcare needs.