

Dragonfly Family Health Centre
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Pediatric Intake form

Date: _____
 Child's Name: _____ Age: _____
 Date of Birth: 20__/____/____ (i.e.2009/may/9) Sex: M F Grade: _____
 Mother's Name: _____ Father's Name: _____
 Home Address: _____ Home Tel: (____) ____-_____
 _____ Bus. Tel: (____) ____-_____
 Name of Medical Doctor: _____ Tel: (____) ____-_____
 How or by whom were you referred to this office? _____
 Has this child been treated by a Naturopath before? Yes ___ No ___
 If 'yes', by whom? _____ When? _____
 Why? _____

Presenting complaint: _____

 Other Complaints (if any) _____

Family Medical History:

Father: _____
 Mother: _____
 Sister(s): _____
 Brother(s): _____
 Maternal Grandparents: _____
 Paternal Grandparents: _____
 Aunt(s): _____
 Uncle(s): _____
 Others: _____

Child's Medical History:

List here:	When?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Immunizations & Reactions (if any):

Measles _____ DTP _____ Smallpox _____
Mumps _____ MMR _____ Diphtheria _____
Polio _____ Tetanus _____ Influenza _____
Other (list): _____

Current Medications:

Please check any of the following medications this child is taking.

	Now	Past		Now	Past
Tempra	_____	_____	Antibiotics	_____	_____
Aspirin	_____	_____	Antihistamine	_____	_____
Tylenol	_____	_____	Decongestant	_____	_____

Others (list): _____
Allergies to Medicine (list): _____

Mother's Pregnancy History

Number of previous pregnancies ____ Number of miscarriages ____ Number of abortions (if applicable): ____
Complications of any of the above: _____
Mother's age at child's birth: ____
Mother's health during pregnancy:
Bleeding _____ Physical or emotional Trauma _____
Nausea _____ Cigarettes, Alcohol, Drug Intake _____
Illnesses _____ Thyroid Problems _____
High Blood Pressure _____ Weight Gain _____
Diabetes _____ Medications _____

Birth History

Term: Full ____ Premature ____ Late ____ Wt. at Birth _____
Length of labour: _____ Complications? _____
Has your child had any of the following problems?
Jaundice _____ Ear Infections _____ Seizures/Convulsions _____
Colic _____ Tonsillitis _____ Birth Defects _____
Blue Baby _____ Cerebral Palsy _____ Birth Injuries _____
Others (list) _____
Allergies (list) _____
Child's sleep patterns (first year): _____
Feeding: Breastfed? ____ How long? ____ Formula ____ Milk/Soy ____
Age began: Sitting _____ Crawling _____
Walking _____ First Words _____
Cut 1st tooth _____ Trained for urine _____ Trained for BM _____

Diet: Please describe your child's 'typical daily diet':

Review of Systems

Please circle any condition this child has presently.

Please place the letter P beside a condition this child has had in the past.

A. General Symptoms

- Fatigue/Weakness
- High Fevers
- Chills
- Night Sweats
- Loss of Weight
- Weight Gain
- Anaemia
- Easy Bruising/Bleeding
- Anxiety/Nervousness
- Unusual Fears
- Cries Easily
- Nightmares
- Sleep Problems
- Motion/car sickness

B. Skin

- Chronic Rash
- Hives
- Eczema
- Psoriasis
- Itchy
- Acne
- Hair Changes
- Nail Changes

C. Head

- Cradle Cap
- Dandruff
- Frequent Headaches
- Migraines
- Head Injury

D. Ears

- Hearing Loss
- Impaired Hearing
- Earaches
- Infections
- Dizzy Spells
- Ringing
- Discharge

E. Eyes

- Impaired Vision
- Eye Pain
- Itching
- Redness
- Tearing
- Dryness
- Blurring
- Glazed
- Bothered by Sun

F. Nose & Sinuses

- Frequent Colds/Flu
- Nose Bleeds
- Hayfever
- Sinus Problems
- Congestion
- Discharge

G. Neck

- Lumps
- Pain/Stiffness
- Enlarged Glands

H. Mouth & Throat

- Frequent Sore Throats
- Frequent Throat Infections
- Loss of Taste
- Sore Tongue /Mouth
- Cankers & Sores
- Bleeding Gums
- Dental Cavities/Fillings
- Breath/Body Odour
- Salivation

I. Respiratory

- Cough
- Wheezing
- Asthma
- Bronchitis
- Pneumonia
- Tuberculosis

J. Cardiovascular

- Congenital Heart Defect
- Heart Murmur
- Chest Pain
- Rheumatic Fever

K. Gastrointestinal

- Stomach aches
- increased/decreased thirst
- increased/decreased hunger
- nausea
- vomiting
- diarrhea
- constipation
- number of BM/day
- belching/passing gas
- hernias
- hypoglycaemia

L. Urinary

- Pain during/after/before
- burning during/after/before
- increased frequency
- urgency
- hesitancy
- inability to hold urine
- wets the bed
- infections
- Blood in urine
- kidney disease

M. Musculoskeletal

- joint pain or stiffness
- broken bones
- muscle spasms or cramps
- muscle weakness
- flat feet

N. Peripheral Vascular

- Cold Hands or Feet
- Extremity: Numbness
- Coldness
- Tingling

O. Neurologic

- fainting
- loss of memory
- involuntary movements
- paralysis
- speech problems

P. Endocrine

- heat intolerance
- cold intolerance
- diabetes

Q. Habits

- plays well alone
- plays well with other children
- plays well with adults
- shy
- clings
- upset easily
- frustrated easily
- destructive
- independent

Thank you for taking the time to fill out this questionnaire.