PICKERING WELLNESS CENTRE

From Pain Relief to Wellness Care Naturally!!

1128 Kingston Road, Pickering, ON, L1V 1B4
Tel: (905) 420-9494 Fax: (905) 420-9449
Email: pickeringwellness@yahoo.ca
Website: www.pickeringwellness.ca
Online Store: www.pickeringwellness.meta-ehealth.com

Naturopathic Intake – CHILD (Please print clearly)

Let's begin your journey towards health. Parent/Guardian please take the time to fill out the following form. It provides me with information to properly assess your case and health. All information is for office use only and will be kept confidential.

Today's Date: _____

PATIENT INFORMATION- CHILD:

Name:_____
(First) (Middle) (Last)
Age: _____ DOB (M/D/Y): _____ Sex (M/F): _____
Height: _____ Weight: _____
Who is filling out this form (name and relation)? _____
How did you hear about Nisha Patel, ND? _____
Extended Healthcare Insurance Company (if applicable):
_____

CONTACT INFORMATION:

Home Address: _____
City: _____ Province: _____ Postal Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____
May we leave messages at the above phone numbers? Y/N
If so, which phone number? _____
Email address: _____

PARENT/GUARDIAN INFORMATION:
Name:_____
(First) (Middle) (Last)
Relation: _____
Home Address: _____
City: _____ Province: _____ Postal Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____
May we leave messages at the above phone numbers? Y/N
If so, which phone number? _____
Email address: _____

EMERGENCY CONTACT INFORMATION:
Name: _____
Relationship: _____

Phone Number: _____
Alternative Phone Number: _____
Email Address: _____

OTHER HEALTH CARE PROVIDERS THE CHILD IS SEEING:

1) Name: _____
Phone Number: _____
Location: _____
Date of Last Visit: _____
Specialty: _____
2) Name: _____
Phone Number: _____
Location: _____
Date of Last Visit: _____
Specialty: _____
3) Name: _____
Phone Number: _____
Location: _____
Date of Last Visit: _____
Specialty: _____

HEALTH CONCERNS:

Please list the child's primary health concerns in order of importance:

1) _____
2) _____
3) _____
4) _____
5) _____

Does the child have any known contagious disease at this time? Y/N
If yes, what? _____

Please list any diagnosis the child has received in the past and present, who diagnosed the condition and the relevant dates:

_____
_____

MEDICAL HISTORY:

How would you describe the child's general state of health? Please circle one
Excellent Good Fair Poor

Please list any serious conditions, illnesses, injuries, and any hospitalizations below, along with their approximate dates: _____
_____
_____

Does the child have any allergies/sensitivities? If so, what to?

_____
_____

Please list all prescription medications, over the counter medications, vitamins or other supplements the child is currently taking with dosages and frequency:

1) _____
2) _____
3) _____

Please list all past prescription medications, over the counter medications, vitamins or other supplements the child has taken: _____
_____

Does the child frequently take any of the following products? (Please circle all that apply)
Aspirin Tylenol Ibuprofen Laxatives Antacids
Diet Pill Cough remedies Antibiotics

Please indicate what immunizations the child has had (DPT, MMR, Haemophilus influenza B, Tetanus, Flu, Hepatitis A, Hepatitis B, Polio, Small pox etc.):
_____
_____
_____
Please indicate if any caused adverse reactions:
_____

Has the child had any of the following, please indicate? Rubella (German measles), measles, chicken pox, mumps, roseola, scarlet fever, whooping cough, strep throat, impetigo, mononucleosis, ear infections, pneumonia, tonsillitis etc.
_____
_____
_____
What screening tests has your child had (blood, hearing, vision etc.)?
_____
_____

PRENATAL HEALTH:
What was the health of the parents at contraception? *Please circle one.*
Mother: Excellent Good Fair Poor
Father: Excellent Good Fair Poor

What was the health of the mother during the pregnancy? *Please circle one.*
Excellent Good Fair Poor

What was the mother's age at child's birth? _____

How was the mother's diet during pregnancy? *Please circle one.*
Excellent Good Fair Poor

Did the mother receive prenatal medical care? Y/N

Did the mother experience any of the following during the pregnancy? *Please circle one.*
Bleeding High blood pressure Nausea Vomiting
Diabetes Thyroid problems Physical or emotional trauma
Others: _____

Did the mother use any of the following during the pregnancy? *Please circle one.*
Tobacco Alcohol Recreational drugs Prescription medicine
Over-the-counter medication Supplements
Others: _____

Birth History:
Term Length: Please circle one and indicate weeks.
Full Premature:_____ Late:_____

Length of labour: _____
Weight of birth: _____
Any complications: _____
_____
Was the birth: vaginal, C-section, induced, forceps, vacuum, or anesthesia used?
_____

Did the child experience any of the following at or shortly after birth? Please circle one.
Jaundice Rashes Seizures Fever
Birth Injuries: _____
Birth defects: _____
Others: _____

Diet:
How was your infant fed and for how long? Please circle one.
Breast fed: _____ Formula: Milk/soy/other:_____
Other: _____

What foods were introduced before 6 months? (Please list approximate month as well.)
_____
_____

6-12 months? _____
_____
_____

Did your child ever experience colic? If yes, for how long?
_____

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

Please describe your typical daily diet, including beverages: (include quantities)
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____

Health and Development:
How was your child's health in the first year?
Excellent Good Fair Poor

At what age did your child first:
Sit up_____ Crawl_____
Walk_____ Talk_____

Describe your child's sleep pattern:
_____
_____

How would you describe your child's temperament? _____

How would you describe your child's behavior and performance at school?
_____

FAMILY HISTORY:
Indicate which of your close relatives suffers from any of the following conditions: (mother, father, grandmother, grandfather, sibling, child)

Alcoholism/Drug Addiction:	Allergies:	Anemia:
Arthritis:	Asthma:	Cancer:
Diabetes:	Eczema:	Epilepsy:
Depression/Other Mental Illness:	High Blood Pressure:	Heart Disease:
Hepatitis:	Headaches:	Kidney Disease:
Stroke:	Tuberculosis:	Osteoporosis:
Liver Disease:	Female Reproductive Problems:	Male Reproductive Problems:
Thyroid Problems:	Autoimmune Disease:	Birth defects:
Juvenile arthritis:	Others:	

Do either of the parents have a chronic illness? If yes, please describe.
_____

ENVIRONMENTAL FACTORS:
Is the child in: *Please circle one*.
School Daycare Homecare Other:_____

What are your child's favorite activities?
_____
_____

Does the child exercise regularly? If yes, how much and how often?
_____

How much television does your child watch? _____hrs a day/week

How often does your child read (not for school), or how often does someone read to your child? *Please circle one*.
Daily Several times a week Weekly Less than weekly

Does anyone in the child's household smoke? Y/N

Are there animals in the home? Y/N Please indicate: _____

How is the child's home heated? Please circle one.
Natural Gas Oil Electric Wood Other:_____

Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies etc.)? Please describe.

_____
_____
_____

How would you describe the emotional climate of the child's home?

_____
_____

Is there any additional important information you would like to provide?

_____
_____
_____
_____

Thank you for taking the time to fill out this form.
Please return to front desk/reception.

_____ _____

Parent/Guardian Signature Date