Marda Loop Naturopathic and Wellness Clinic

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PEDIATRIC INTAKE FORM (AGES 0-16 YEARS)

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Patient information contained within this form is considered strictly confidential. Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible care.

***Please note**: this form is intended for children ages 0-16yrs; if a question does not apply for your age, just mark N/A.*

Today's Date:

Name:	*First*	*Middle*	*Last*
Address:	*Street*		
	City	*Province*	*Postal Code*
Phone:	*Home*	*Work*	*Cell*
Email:			
Emergency Contact:	*Name*	*Relationship*	*Phone*
Date of Birth:	*MM/DD/YYYY*		
Gender:	*M F*		
School:			
Insurance:			
Medical Doctor:	*Name*	*Phone*	*Last physical: DD/MM/YY* *Last Blood work: MM/YY*
Dentist:	*Name*	*Phone*	*Last check-up: DD/MM/YY*
Would you like to receive:	Email appointment reminders? Yes / No		
How did you hear about us?			

Who is filling out this form (name and relationship)?______________________________

Please give a brief, detailed description of the problem(s) you are currently experiencing, in descending order of importance, with the date of diagnosis if applicable:

____
____
____
____

What seemed to be the initial cause (s) of your concerns?______________________________

Have you tried other conventional or complimentary treatments? If so, what were they and what were the results?

____
____
____

Are you currently receiving any other treatments? If so, please list the practitioner and type of treatment.

____
____

What are your expectations for coming to our clinic?

____
____
____
____

Name ______________________________

MEDICAL HISTORY

Please mark (c) for current problems, or check and indicate the age when you had the following:

Eyes
- ☐ Colour blindness
- ☐ Eye pain
- ☐ Glasses or contacts

Ears
- ☐ Dizziness
- ☐ Ear ache
- ☐ Foreign objects
- ☐ Impaired hearing
- ☐ Ringing in the ears

Nose
- ☐ Loss of smell
- ☐ Nasal congestion
- ☐ Nosebleeds
- ☐ Sinus infections

Throat
- ☐ Frequent colds
- ☐ Hoarseness
- ☐ Sore throat (chronic)
- ☐ Tonsillitis

Respiratory
- ☐ Chronic cough
- ☐ Hay fever (or seasonal allergies)
- ☐ Shortness of breath
- ☐ Coughing up phlegm/blood
- ☐ Wheezing

Cardiovascular
- ☐ Chest pain
- ☐ Cyanosis
- ☐ Easy bruising
- ☐ Fainting
- ☐ Heart murmurs
- ☐ Irregular pulse
- ☐ Palpitations
- ☐ Poor circulation
- ☐ Slow wound healing

Endocrine
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Fatigue
- ☐ Heat/cold intolerance
- ☐ Hypoglycemia
- ☐ Hypothyroid

Gastrointestinal
- ☐ Abdominal pain/bloating
- ☐ Bloody or black stools
- ☐ Colitis/Crohn's
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Poor appetite
- ☐ Excessive gas
- ☐ Heartburn/reflux
- ☐ Intestinal worms
- ☐ Jaundice (yellow skin)
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful bowel movements
- ☐ Vomiting

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Genital lesions/discharge
- ☐ Kidney infection

Urination
- ☐ Blood in urine
- ☐ Change in frequency
- ☐ Incontinence
- ☐ Odor
- ☐ Painful urination
- ☐ Urgent urination

Male
- ☐ Hernia
- ☐ Testicular mass
- ☐ Testicular pain
- ☐ Penile discharge

Female
- ☐ Menses
- ☐ Rash
- ☐ Vaginal itching
- ☐ Vaginal discharge

Mental-emotional
- ☐ Anger
- ☐ Anxiety
- ☐ Colic
- ☐ Depression
- ☐ Insomnia
- ☐ Irritability
- ☐ Hypersomnia
- ☐ Memory loss
- ☐ Mental disorder
- ☐ Mood swings
- ☐ Nervousness
- ☐ Nightmares
- ☐ Suicidal thoughts
- ☐ Teeth clenching/grinding

Muscle/Joint/Pain
- ☐ Back/neck pain
- ☐ Broken bone
- ☐ Bursitis
- ☐ Concussion
- ☐ Foot trouble
- ☐ Head injury
- ☐ Headaches
- ☐ Imbalance
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Migraines
- ☐ Numbness/tingling
- ☐ Sciatica
- ☐ Sprain/strain
- ☐ Tremors

Skin
- ☐ Acne/boils
- ☐ Cradle cap
- ☐ Dryness
- ☐ Easy bruising
- ☐ Eczema or hives
- ☐ Itching
- ☐ Hair loss
- ☐ Rash

Check any conditions you have or have had:
- ☐ Anemia
- ☐ Appendicitis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes/hyperglycemia
- ☐ Eczema
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ Herpes
- ☐ HIV/AIDS
- ☐ Impetigo
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Mumps
- ☐ Pneumonia
- ☐ Rheumatic fever
- ☐ Roseola
- ☐ Rubella
- ☐ Tuberculosis
- ☐ Scarlet fever
- ☐ Strep throat
- ☐ Ulcers

Have you…
- ☐ Been hospitalized in the last 5 years?
- ☐ Had any recent surgeries?
  If yes, explain: ______________
  ____
- ☐ Had any other major procedures in the last 5 years?
  If yes, explain: ______________
  ____

ALLERGIES

Please list any allergies to medications: ______________________________

Please list any environmental allergies: ______________________________

Please list any known food allergies: ______________________________

Please list any other allergies: ______________________________

Name ______________________________

FAMILY MEDICAL HISTORY

Relation	Age	Living/Dead (L/D)	Medical Condition (s) or cause of death
Father			
Mother			
Brother (s)			
Sister (s)			
Maternal GM			
Maternal GF			
Paternal GM			
Paternal GF			
Other			

Are there any other medical conditions that run in the family? ______________________________

____

PEDIATRIC PROFILE

	Mother		Father	
Name				
Age				
Present health status				
Smoker	☐ Yes	☐ No	☐ Yes	☐ No
Alcohol	☐ Yes	☐ No	☐ Yes	☐ No
Employed	☐ Part-time	☐ Full-time	☐ Part-time	☐ Full-time
Stress Level (1-10, 10 most stressed)	1 2 3 4 5 6 7 8 9 10		1 2 3 4 5 6 7 8 9 10	

Mother

Number of previous pregnancies: ______________________________

Describe your experience with this pregnancy (emotions, complications, concerns): ______________________________

____

____

Please list any infections, illnesses or complications during pregnancy: ______________________________

____

- ☐ Nausea/vomiting
- ☐ Diabetes
- ☐ Anemia
- ☐ High blood pressure
- ☐ Physical or emotional trauma
- ☐ Multiple pregnancy

Therapies during pregnancy:

- ☐ Tobacco
- ☐ Alcohol
- ☐ Recreational drugs. If yes, please list: ______________________________
- ☐ Prescription/OTC drugs: ______________________________
- ☐ Supplements: ______________________________
- ☐ Other: ______________________________

Describe your diet during pregnancy (including cravings): ______________________________

____

____

Labour and Delivery:

Birth weight: ______________________________

Duration of pregnancy: ______________________________

Duration of labour: ______________________________

Type of delivery (natural vaginal/water/C-section): ______________________________

Medications and anesthesia (type, duration, any reactions): ______________________________

Any complications: ____
APGAR score: ____
Congenital abnormalities (list): ____

Childhood:
Breastfed and how long: ____
Age of formula introduction: ____
Age of introduction of solid foods: ____

Developmental Milestones:
When did you first: Sit up__________ Crawl__________ Walk__________ Talk__________Fully toilet trained__________

Psychosocial:
Hobbies and favourite activities: ____
How often do you watch TV/play video games? __________hrs/day
Does anyone in the home smoke? Yes/No
Any pets? Please list____

MEDICATIONS

Please list your medications below in as much detail as possible and bring your bottles with you to your appointment:

Drug	Dosage	Start Date	Reason

Please list past medications and their purpose___________________________________
How many times have you taken antibiotics?__________

SUPPLEMENTS

Please list any supplements you are currently taking along with brand and dosing:
____
____
____

VACCINATIONS

- ☐ Are you up to date on your vaccines Yes No
- ☐ Any additional vaccines____
- ☐ Any reactions to vaccines____

Have you traveled outside Canada recently? If so, where?___________________________

LIFESTYLE

Energy and Stress
Rate your energy level: Low 1 2 3 4 5 6 7 8 9 10 High
Rate your stress level: Low 1 2 3 4 5 6 7 8 9 10 High
Do you exercise/play? Yes No If yes, what type and how often? ____________________
Do you watch TV? Yes No If yes, how much?__________________________________

Sleep:
Do you have trouble falling asleep? Yes No
Do you sleep through the night? Yes No
Do you wake feeling refreshed? Yes No
Do you nap? Yes No How long and how often:______________________
How many hours of sleep do you normally get?______________________________

Name ___________________________

Home Environment

Do you live close to any of the following? Circle all that apply.

Airport Dump Highway Industry Power Lines Cell Phone Tower

Have you done any major renovations in your home recently? Yes No

How old is your home? ___________ How long have you lived in your current home?___________

Do you have any household pets? ___________________________

Have you ever been exposed to any toxic chemicals or heavy metals? Yes No If yes, describe:___________

DIET

Do you have any known food intolerances or allergies? If so, please list.___________________________

Do you have any dietary preferences___________________________

How many meals do you generally eat each day?___________________________

How is your appetite?___________________________

Do you drink soft drinks? Yes No If yes, how often?___________________________

Describe a typical day's diet:

Breakfast___________________________

Snack___________________________

Lunch___________________________

Snack___________________________

Dinner___________________________

Snack___________________________

Beverages___________________________

How much water do you drink in a day? ___________________________

Height:___________ Weight:___________ Weight 1 year ago:___________

Is there anything else our staff needs to know about you?___________________________

CONTEXT OF CARE

Please answer the following to the best of your ability.

1. What long-term goals do you have from working with us?
   a)___________________________
   b)___________________________
   c)___________________________

   What expectations do you have of me personally as your physician?
   a)___________________________
   b)___________________________
   c)___________________________

2. What is your present level of commitment to address any underlying causes of your signs and symptoms? (Rate from 1 to 10, 10 being 100% committed) 1 2 3 4 5 6 7 8 9 10

3. What do you LOVE to do?
   ____
   ____
   ____

Name ________________________________

Adolescent Addendum: Ages 13-16 Only

To be filled out by patient if between ages 13-16 years.

Lifestyle

Do you smoke? Yes No In the past If yes, for how long?______________ Packs per day:_______________
Do you do any recreational drugs? Yes No
How often do you drink alcohol? ____
Do your drink coffee? Yes No If yes, how much?______________________________________
Are you sexually active? Yes No If yes, are you using any birth control? Yes No Type:____________________

Psychosocial

How would you describe your relationship with:

	Excellent	Good	Ok	Poor
Parents	☐	☐	☐	☐
Siblings	☐	☐	☐	☐
Friends	☐	☐	☐	☐

What is your stress level? Please indicate on a scale of 1 (least) to 10 (most):
Home: ____________ School: ____________ Other (list):____________
What are your goals (life, career, relationships):_____________________________________

Reproductive Health

Male:
Age of onset of puberty: ______yrs
Have you noticed any changes that you would like to talk about?:_____________________________

Female:
When did you have your first period? ____________yrs
Average days of bleeding (period): ____________days
Average days between bleeding: ____________days
Is there any bleeding between periods? Yes/No
When was your last PAP exam? ____
Have you ever been pregnant, had a live birth, miscarriage or abortion? Yes/No ______________________________

Is there anything you would like to talk about in private today? Yes/No