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Naturopathic Doctor

Mandzak Chiropractic Health Centre
101 Mary St. West, #101, Whitby, ON

PEDIATRIC
Patient Intake Form

Last Name	First Name	Middle Name	
Date	Date of Birth M/D/Y	Age	Sex
Who is filling out this form: Name:	Relationship:		

Contact Information

Street Address	Town/City	Province	Postal Code
Home Phone Number	Alternative Phone Number	May we leave messages regarding your appointment? Yes/No	
Email address			
Who does the child live with?			

Emergency Contact Information

Name	Relation	Phone Number
Name	Relation	Phone Number

Other Health Care Providers

Name	Specialty/Focus	Contact Info
Name	Specialty/Focus	Contact Info
Name	Specialty/Focus	Contact Info
Date of Last Medical Visit	Date of Last Physical Exam	Date of Last Blood Work
List of Routine Screening Tests Performed by Other Physicians:		

How did you hear about this clinic?		If referred➔ please let us know by whom:
Have you been treated by a Naturopathic Doctor (ND) before?	Name of ND:	Date of Last Visit

Health History

In your opinion what are your child's most important health concerns?

1. _____

2. _____

3. _____

4. _____

5. _____

6.

Current Height	Current Weight	Past Max Weight	Past Min Weight

Vaccination / Immunization Record: Check all that apply

Please note vaccinations in **bold** are considered routine as per the Ontario Childhood Immunization Schedule 2004

- ☐ **DPT (Diphtheria, Pertussis, Tetanus)**
- ☐ **MMR (Measles, Mumps, Rubella)**
- ☐ **Hepatitis B**
- ☐ **Polio**
- ☐ **Varivax/Varilrix (Chicken Pox)**
- ☐ **Pneumococcal Conjugate (Meningitis/Pneumonia)**
- ☐ **Meningococcal C Conjugate (Meningitis)**
- ☐ Other: _____
- ☐ Gardasil/Cervarix (HPV Vaccine)
- ☐ Haemophilus Influenza B
- ☐ Hepatitis A
- ☐ BCG (Tuberculosis)
- ☐ Flu Vaccine

Did any of your vaccines cause adverse reactions, if yes: _____

Which of the following childhood illnesses have you had? Check all that apply:

- ☐ Asthma
- ☐ Rheumatic Fever
- ☐ Rubella (German Measles)
- ☐ Polio
- ☐ Scarlet Fever
- ☐ Whopping Cough
- ☐ Mumps
- ☐ Roseola
- ☐ Chicken Pox
- ☐ Measles

List all Diagnosed Medical Conditions:	**Treatments Received:**	**Year of Diagnosis:**

List all Surgeries/Medical Procedures:	**Reason:**	**Date (Year/Month)**

List all Allergies (medications, foods, supplements, environmental, etc.)	**Reaction Type**

List all prescription drugs, over-the-counter medications (pain killers, antacid, etc), **herbs and natural supplements** (vitamins, homeopathics, etc) **that you are taking:**

Medication	Dosage	Start Date

Family History

Include: heart disease, high blood pressure, cancer, diabetes, depression and other mental illness, drug and alcohol abuse, kidney disease, arthritis, infertility, headaches, neurological conditions, hyper/hypothyroid and other relevant information

Father Age: Related Health History:	**Mother** Age: Related Health History:
Grandmother (Paternal) Age: Related Health History:	**Grandmother (Maternal)** Age: Related Health History:
Grandfather (Paternal) Age: Related Health History:	**Grandfather (Maternal)** Age: Related Health History:

Siblings	**Age**	**M/F**	**Health History**
1.			
2.			
3.			

Birth History

Term	Full/Premature #of weeks premature: _____ # of weeks late: _____	
Mother's Health	How was the mother's health during pregnancy?	Did the mother receive prenatal care?
	What was the mother age at child's birth?	
	Did the mother experience any of the following during pregnancy: bleeding/high blood pressure/nausea/vomiting/diabetes/thyroid problems/emotional or physical trauma	
Labour	Length of labour: _____ Any Complications? _____ Weight at birth: _____ Vaginal/C-section Induced Forceps	
At Birth	Did your child experience any of the following? Jaundice/Rashes/Seizures/Birth Injuries Birth defects Other:_____	

Diet and Lifestyle

Diet	Breast fed?	If YES, how long?
	Formula fed/Other?	If YES, how long?
	At what age did you introduce solid foods?	Initial foods: Any reactions:
	Did your child experience colic? Yes/No	
	Does your child have any dietary restrictions (religions, vegan/vegetarian)?	
Health and Development	How would you rate your child's health? Poor Fair Good Excellent	
	Has your child met all developmental milestones?	
	How would you describe your child's temperament/mood?	

	How would you describe your child's behaviour at school/daycare?	
Sleep	On average how many hours/night? _____ Does your child have trouble falling asleep? Yes/NO	Do your child wake up during the night? Yes/No How many times? _____
Energy	On a scale 1(lowest)➔10(highest), rate your child's energy level:	
Stress	What are sources of stress in your child's life:	
Toxins	Is your child exposed to second hand smoke?	Is your child exposed to toxins? Please specify
Please use this space for any information you feel is important but has not been covered:		