BOUCHER INSTITUTE OF NATUROPATHIC MEDICINE
PEDIATRIC INTAKE FORM

NAME:_____AGE:_____SEX:M/F BIRTHDATE:_____

NAME OF PRIMARY CARE GIVER:_____ADDRESS:_____

PHONE# _____ _____

WHAT ARE YOUR HEALTH CONCERNS TODAY? (In order of serverity)

1.)_____

2.)_____

3.)_____

HISTORY OF ILLNESS:

- ☐ CHICKEN POX
- ☐ RED MEASLES
- ☐ MUMPS
- ☐ RUBELLA
- ☐ SCARLET FEVER
- ☐ RHEMATIC FEVER
- ☐ STREP THROAT
- ☐ PNEUMONIA
- ☐ MONONUCLEOSIS
- ☐ EAR INFECTION
- ☐ TONSILITIS
- ☐ OTHERS (Pleases specify) _____

IMMUNIZATION SCHEDULE

- ☐ HEPATITIS B
- ☐ DPTP
- ☐ HIB
- ☐ MMR
- ☐ TdP
- ☐ ANY REACTION TO A VACCINE ☐ YES ☐ NO

MEDICATIONS AND SUPPLIMENTS:

(Including any over counter medications, antibiotics, minerals, vitamins and herbs)

_____

_____

_____

NEONATAL HISTORY:

BIRTH WEIGHT:_____

☐ PREMATURE ☐ FULL TERM ☐ LATE

HEALTH PROBLEMS DURING NEWBORN PERIOD:

- ☐ JAUNDICE
- ☐ ANEMELIA
- ☐ RESPIRATORY
- ☐ STOMACH INVESTINE
- ☐ CONVULSIONS/SEIZURE
- ☐ OTHERS (Please specify)

INFLANT FEEDING:

☐ BREAST FED ☐ FORMULA

IF BREAST FED, HOW LONG?_____

IF FORMULA: TYPE _____

AMOUNT IN 24HRS_____

DURATION _____

SOLID FOOD:

AGE OF INTRODUCTION: 3999 monyj

TYPE OF FOODS:_____

DIFFICULTIES:_____

(e.g. Colic, regurgitation, vomiting, darrhea)

DEVELOPMENT: ESTIMATED AGE OF:

ROLLING OVER _____

SITTING _____

WALKING _____

TALKING WORDS _____

TOILET TRAINING _____

SUBSEQUENT HOSPITALIZATION/SURGERY/ACCIDENT/SERIOUS ILLNESS/INJURY (describe and give dates)

_____

_____

_____

CHILD BEHAVIOURAL CHALLENGES:

- ☐ TANTRUMS
- ☐ SCREAMING
- ☐ IMPULSIVE BEHAVIOURS
- ☐ AGGRESSION
- ☐ HYPERACTIVITY
- ☐ EASILY DISTRACTABLE
- ☐ BOWEL URINARY INCONTINENCE

SLEEP DISTURBANCES:

- ☐ FREQUENT AWAKENINGS
- ☐ BREATHING PROBLEMS
- ☐ BED WETTING
- ☐ LOUD SNORING
- ☐ NIGHT TERRORS
- ☐ TIRED UPON RISING IN THE MORNING

CHILD SCHOOL ACTIVITIES

FAVORITE SUBJECTS: _____
WORST SUBJECT: _____
GENERAL PERFORMANCE: _____
RELATIONSHIP WITH FRIENDS: _____
EXTRACIRCULAR ACTIVITIES: (please specify)_____

CHILD DIET HISTORY:

FOOD PREFERENCES: _____
FOOD AVOIDANCE: _____
FLUID CONSUMPTION/DAY: _____
TYPES OF BEVERAGES: _____
MEAL TIMES: _____
CONFIRMED FOOD ALLERGIES: _____
ILL EFFECTS FROM SPECIFIC FOODS:_____

MOTHER'S HISTORY:

AGE AT BIRTH OF CHILD:_____
PREVIOUS PREGNANCY: ☐ YES ☐ NO
ANY MISCARRIAGE/ABORTION ☐ YES ☐ NO
PREGNANCY DURATION: _____
TYPE AND TIME OF FETAL MOVEMENT:_____

TESTS DONE DURING PREGNANCY:

- ☐ ULTRASOUND
- ☐ CVS
- ☐ AMNIO
- ☐ OTHERS, please specify:_____

DELIVERY:

TYPE: _____
LABOUR DURATION: _____
COMPLICATIONS (please specify): _____

DURING PREGNANCY:

MOTHER'S HEALTH:
_____
(e.g. illness, accidents, morning sickness)

MOTHERS SUPPLIMENTS:
_____

MEDICATIONS:
_____

USE OF DRUGS, ALCOHOL, SMOKING
☐ YES ☐ NO if yes, please specify:_____

DIETARY AND EXERCISE HABITS:
_____

DENTAL AMALGAMS AQUIRED OR REMOVED:
☐ YES ☐ NO

FAMILY HISTORY

(if there are past illnesses in siblings, parents, or extended family members that relate to patient, please specify)

_____
_____

ANY OTHER COMMENTS OR CONCERNS: (please specify)

_____
_____
_____