Radiant Life
Naturopathic Centre

Confidential Pediatric Case History

Please help me to understand your child's health needs by carefully completing this intake form.

Child's Name: _____ **Age:** _____ **Sex:** _____

Date of Birth: _____ _____ _____ **Care Card # (PHN):** _____
(Month) (Day) (Year)

Parent/Guardian Information:

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Email Contact: _____ **Address:** _____

City: _____ **How did you hear about the clinic?** _____

Please list all of your child's known allergies (medications, foods, airborne, etc): _____

_____

Please list the reasons for your child's visit

1. _____ **3.** _____

2. _____ **4.** _____

What expectations do you have from this visit to our clinic? _____

Please list any medications or natural supplements your child is presently taking: _____

_____

Weight: _____ **Weight:** _____

How often does your child have a bowel movement? _____

How is your child's energy? ☐ **Extremely Low** ☐ **Barely Enough** ☐ **Good** ☐ **Excellent** ☐ **Too High**

Please describe a typical day of eating for your child:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks/Beverages: _____

Radiant Life
Naturopathic Centre

Medical History:

Please list any serious injuries/hospitalizations/illness/trauma, with brief details:

_____ **Year:** _____ _____ **Year:** _____

_____ **Year:** _____ _____ **Year:** _____

History of antibiotic use? Yes ☐ No ☐ Approximate dates: _____

IMMUNIZATIONS – What vaccines has your child had?

☐ **MMR**	☐ **Polio**	☐ **Hep A**	☐ **Pneumo**	☐ **Rotavirus**
☐ **DTaP**	☐ **HiB**	☐ **Hep B**	☐ **Men-c**	☐ **Chicken pox**

Any adverse reactions to vaccinations? Yes ☐ No ☐ If yes, please describe: _____

Mother's Health During Pregnancy:

☐ **Diabetes** ☐ **High blood pressure** ☐ **Severe morning sickness** ☐ **Smoking/alcohol/drugs**

☐ **Thyroid condition** ☐ **Other** _____ ☐ **Mother's age at birth:** ____

Birth History:

Term: ☐ **Full** ☐ **Premature** ☐ **Late** ☐ **Birth weight:** _____

Birth: ☐ **Vaginal** ☐ **C-Section** **Birth complications:** _____

Feeding: Breastfed? Yes ☐ No ☐ How long: _____ **When was food introduced?** _____

Family History: Has anyone in your child's immediate family been diagnosed with the following?

☐ **Autoimmune condition** ☐ **Diabetes** ☐ **Heart Disease** ☐ **Cancer: type(s)** _____

☐ **Mental illness** ☐ **Thyroid disease** ☐ **Other** _____

Overview of Body Systems:

Has your child had any of the following conditions in the past or currently:

☐ **Allergies**	☐ **Colic**	☐ **Dry skin**	☐ **Heart murmur**	☐ **Stuffy nose**
☐ **Anemia**	☐ **Cough/Wheeze**	☐ **Earache(s)**	☐ **High fever**	☐ **Thrush**
☐ **Asthma**	☐ **Croup**	☐ **Eczema/rashes**	☐ **Insomnia**	☐ **Vomiting spells**
☐ **Bedwetting**	☐ **Depression**	☐ **Frequent infections**	☐ **Jaundice**	☐ **Other** _____
☐ **Birth defects**	☐ **Diarrhea**	☐ **Headaches**	☐ **Learning problem(s)** _____	

Is there any other information that I should know about your child?

_____