Pediatric/Youth Naturopathic Intake Form

Dr. Kelly Upcott-Siebert B.Sc. N.D.

Origins Naturopathic Retreat, 1211 County Rd 20, Kingsville 226-774-2106

Lifetime Wellness Center, 401-3090 Dougall Ave, Windsor 519-250-6288

Email: info@kellyupcottnd.com

Website: kellyupcottnd.com

Please fill out this form and bring to your initial visit

Confidential Patient Information Date: ______________________

Patient's Name: ______________________ Date of Birth: ______________ Age: _____ Sex: M F
(dd/mm/yyyy)

Name of Parent(s) / Guardian: ______________________________________

Full address: ____
(Street Address / City / Province / Postal Code)

Telephone: ______________________ / ______________________ /______________________
(Home) (Mobile) (Business)

Email(s): ____

Emergency Contact: ______________________ ______________________ ______________________
Full Name Relation Telephone

Patient's Primary Caregiver / Physician: ______________________ ______________________
Telephone

Please complete the following questions:

What are the main health concerns that bring you here today?
(Please list as many as applicable and in order of importance. You may include the onset, location, previous treatments)
1) ____
2) ____
3) ____
4) ____
5) ____

Medications: Please list any current (c) or previous (p) medications the patient is taking

____
____
____
____
____

Please list any vitamins, herbs, homeopathies, or supplements the patient is currently taking

____
____
____

Allergies: Please list any allergies the patient has (ie- medications, foods, chemicals)

____
____
____

Immunization: Please check any vaccinations the patient has received and any reactions that followed

☐ MMR Reactions: ____________
☐ HepB Reactions: ____________
☐ Influenza (Hib) Reactions: ____________
☐ DPT Reactions: ____________
☐ Chickenpox Reactions: ____________
☐ Polio Reactions: ____________

Health History: Please mark "N" for now, "P" for past, "B" for both

_____ Anxiety
_____ Chicken Pox
_____ Measles
_____ Mumps
_____ Rashes / Hives
_____ Ear Infections
_____ Frequent Colds
_____ Bed Wetting
_____ Food Sensitivities
_____ Gas/Bloating
_____ Pneumonia
_____ Fractures
_____ Headaches
_____ Couch/Wheezing
_____ Asthma
_____ Jaundice
_____ Diarrhea
_____ Constipation
_____ Influenza
_____ Runny Nose
_____ Nose Bleeds
_____ Dizziness
_____ Nightmares
_____ Bladder Infection

Other: ____
____
____
____

Surgeries / Hospitalizations: Please include dates and or reasons for the following:

____
____
____

Family History: Please indicate family member to which history applies

Allergies		Heart Disease	
Multiple Sclerosis		Multiple Dystophry	
Asthma		High Blood Pressure	
Eczema		Kidney Disease	
Cancer		Mental Illness	
Seizers		Cerebral Palsy	
Endocrine Disease		Migraines	
SIDS		Mentally Handicap	
Diabetes		Depression	

Other: ____

Any siblings? Y N If yes, please indicate names and ages: ______________________________
____
____

Are parents divorced or separated? Y N If yes, with whom does the child live? ______________

Any Pets? Y N If yes, what type(s)? ____

Birth History: Birth Weight: ____________ Birth Height: ____________ APGAR Score: ______________
Type of Birth: ☐ Vaginal, ☐Caesarian Any interventions used (ie- Forceps): ____________________________
Location: ☐ Hospital, ☐ Home, ☐Other: ______________________ If hospital, length of stay: _______________
Complication to mother or baby: Y N If yes, describe: ____
Length of Labour: ______________________ Term: ☐ Premature, ☐ to term, ☐ late, ☐ induced
Age of parents at birth: _________________ Pounds gained by mom during pregnancy: ______________
Did mother smoke during pregnancy? Y N If yes, how much? ____
Any alcohol / drugs consumed during pregnancy: _________________ If yes, how often? ___________

Neonatal History: Please check any that apply

- ☐ Jaundice
- ☐ Colic
- ☐ Respiratory problems
- ☐ Heart problems
- ☐ Cleft palate/lip
- ☐ Spina bifida
- ☐ Scoliosis
- ☐ Cataracts / glaucoma
- ☐ Hip problems

Other: ____

Developmental Milestones: Please indicate age

_____ Teething
_____ Sat alone
_____ Rolled over
_____ Pulled self up
_____ First steps
_____ First words
_____ First sentences
_____ Fed self
_____ Dressed self
_____ Tied shoe laces
_____ Toilet trained
_____ Rose a bike

Compared to others in family, development was ☐ slow, ☐ average, ☐fast

Nutrition:
Was child breast fed? Y N If yes, for how long? _____________ What age were foods introduced: ______
1st foods: _______________________________ Any reactions: ____
Does child have good appetite? Y N How many meals per day? ______________________________
What are child's favourite foods? ____
Does the child have any diet restrictions? Y N If yes, please list: _________________________________

24-hour typical diet diary: Include typical amounts

Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____
Beverages:____

Education: School Name: _______________________________ Phone Number: ___________________________
Type of school: ☐ public ☐ private ☐ home school ☐ other: ____
Grade: ________________ Please check if applicable: ☐ special education ☐ gifted program
Has the child even been held back in school? Y N If yes, which grade(s)? ________________________
Does the child enjoy school? Y N What are the usual grades received? ___________________________
Which subjects does the child enjoy? ____
Which subjects does the child dislike? ____

Housing: please check what is applicable
☐ Apartment ☐ House ☐ Carpeting ☐ Electric heat ☐ Gas heat
How old is the home? ______________ Any recent renovations? ____
Does the home contain any mold, excess dust, fungus, etc? Y N What type? ________________________
Location of home: Close to ☐ powerlines ☐ airport ☐ highway ☐ trees ☐ industry

Habits: Does he/she exercise regularly? Y N What activities and how often? ___________________________

____

How much time does the child spend outdoors? ____

How much sleep per night? ________ Do they wake feeling rested? Y N

Do they have nightmares / night terrors? Y N If yes, how often? ____________________________________

At what age did the child first sleep through the night? ____

Do they watch television? Y N If yes, how many hours per day? ______________________________________

Do they read books? Y N If yes, how many hours per day? ____

Do they have many friends? Y N Do they make friends easily Y N

What are the child's interests? ____

Review of Systems: Please put an "N" for now, "P" for past, "B" for both

Mental / Emotional

_____ Anxiety / Fears
_____ Depression
_____ Weeps easily
_____ Mood swings
_____ Poor concentration
_____ Memory problems

Skin / Hair

_____ Rashes
_____ Easily bruised
_____ Diaper rash
_____ Hives
_____ Acne
_____ Eczema
_____ Lice / nits
_____ Itching
_____ Hair loss

Head

_____ Headaches
_____ Fever
_____ Migraines

Nose / Sinuses

_____ Frequent colds
_____ Seasonal allergies
_____ Chronic runny nose
_____ Nose bleeds
_____ Sinus problems
_____ Loss of smell

Ears

_____ Earaches
_____ Loss of hearing
_____ Dizziness / ringing

Mouth / Throat

_____ Frequent sore throat
_____ Cavities
_____ Sores in mouth

Immune

_____ Frequent infections
_____ Swollen glands
_____ Slow wound healing

Respiratory

_____ Shortness of breath
_____ Asthma
_____ Frequent cough
_____ Bronchitis
_____ Wheezing
_____ Cough blood

Cardiovascular

_____ Palpitation
_____ Chest pain

Gastrointestinal

_____ Stomach aches
_____ Diarrhea
_____ Constipation
_____ Bloating / gas
_____ Change in appetite
_____ Change in thirst

Genitourinary

_____ Frequent infections
_____ Dribbling
_____ Bedwetting
_____ Frequency at night

Musculoskeletal

_____ Muscle aches
_____ Stiffness
_____ Cramps / spasms