Reina Persaud, B.Sc., N.D.

Pediatric Intake Form

The information you provide on this form is intended to aid a comprehensive evaluation. Please take the time to complete the form fully and carefully. All information provided shall be held in the strictest confidence. If you have questions, please ask. Additional details not supported by the form can be noted in the *Additional Information* section. **Please print**.

Date: _____
(month / day / year)

Child Information

CHILD'S FULL NAME: _____

BIRTH DATE: _____ **GENDER:** **Female / Male**
(month / day / year)

HEIGHT: _____ **WEIGHT:** _____

Parent/Guardian Information

NAME AND ADDRESS: _____

_____

_____

FAMILY STATUS: **Single ( ) Married ( ) Common Law ( )**

HOME PHONE: _____ **WORK PHONE:** _____

General Practitioner Information

NAME AND ADDRESS: _____

_____

_____

BUSINESS PHONE: _____

REFERRAL NAME (if applicable): _____

CHIEF CONCERN(S) if applicable: _____

⇒ **how long?** _____

⇒ **prior treatment(s)** _____

⇒ **results?** _____

Histories

CHILD **MEDICAL:**

⇒ **past concerns** _____

⇒ **hospitalizations / surgery/ medications** _____

IMMUNIZATION: **(Please circle those received)**

Hepatitis B Pneumococcal Hemophilus B Pertussis Polio

Measles Mumps Rubella Tetanus Influenza Diphtheria

Adverse reactions? _____

ALLERGENS: **(Please circle)**

⇒ **past experiences:** **eczema hives wheezing asthma stuffy nose (constant cold)**

⇒ **known allergies to:** **medicines? injections? food stuffs? (if yes to any, please detail)**

_____

FAMILY

	Age	General Health	Specific Disease
Mother:			
Father:			
Siblings:			
Grandparents:			

Histories

PRENATAL

Difficulties: (Please circle those experienced)

gestational diabetes thyroid conditions nausea/vomiting

emotional trauma physical trauma high blood pressure

toxemia bleeding nutritional deficiencies

weight gain stress infections

At time of conception, mother's and father's age/health:

Mother's Age: _____ Health: _____

Father's Age: _____ Health: _____

Mother's Exposure: Please ✕ and detail 'Yes' answers

	No	Yes	Detail
Alcohol			
Drugs (recreational/smoking)			
Medications/Supplements			
Toxins			
Diseases			

Travel during your pregnancy? Yes / No (If yes, describe: _____)

Work during your pregnancy? Yes / No (If yes, detail: _____)

Have any of your children died? Yes / No

BIRTH

Did baby deliver on time? Yes / No (If no, + weeks = _____ or – weeks = _____)

Delivery method? Hospital / Other (explain): _____

Number of pregnancies? _____ **Number of Miscarriages?** _____

Any interventions? pain medications / epidural / forceps / vacuum / pitocin

other: _____

Length of Labour: _____ **Spontaneous?** _____ **Induced?** _____

Caesarean? Yes / No **Birthweight (lbs.):** _____ **Length:** _____

Head circumference: _____ **Apgar Score:** _____

Post-partum state/incidents? _____

(describe) _____

Detail any problems child had during delivery (breathing, etc.): _____

_____

Histories

Conditions/Illnesses: Please ✕ and detail 'Yes' answers

	No	Yes	Detail
Chicken pox?			
Measles?			
Mumps?			
Whooping cough?			
Rubella?			
Convulsions?			
Jaundice?			
Infections (e.g. pneumonia)?			
Rashes?			
Diarrhea/constipation?			
Colic?			
Eczema?			
Dental caries?			
Anemia?			
Adequate weight gain?			
Poor feeding?			
Discharges?			
Growing pains?			
Bloody noses?			
Broken bones?			
Congenital abnormalities?			
Motion sickness?			
Ear infections?			
Frequent colds?			
Respiratory distress?			
Household Pets?			
Sensitivities (foods, light, etc.)			

Histories

FEEDING

Breast-fed? Yes / No **How long?** _____ **On demand?** Yes / No

Formula used? Yes / No **If yes, when introduced?** _____

Exclusive or with supplementation? (please circle)

Type of formula used: _____

Introduced to solid foods? Yes / No **If yes, what & when?** _____

When was cow's milk introduced? _____ **Current diet (picky eater?)** Yes / No

List foods excluded from diet _____

General

SLEEPING HABITS

Describe the following:

During first year: _____

At present: _____

Napping habits: _____

Trouble staying awake/falling asleep: _____

BEHAVIOUR & EMOTIONAL HISTORY

At school: Performance / anxiety / separation anxiety

other: _____

At home: ⇒ describe relationship with friends, family, siblings:

_____

⇒ potty training: _____

⇒ interests/activities: _____

Circle any of the following that your child has: nail biting thumbsucking nightmares bad temper fears irritability wets bed speech problems jealousy can't toilet train breath holding self abuse habits

MILESTONE AGES

Sitting: _____ **Walking:** _____

Talking: _____ **Rolling over:** _____

First tooth: _____ **Dressed self:** _____

Additional Information

Informed Consent

Dr. Reina Persaud, B.Sc., N.D.
Doctor of Naturopathic Medicine

I hereby request and consent to the diagnostic and therapeutic procedures required for my health treatment by the Doctor of Naturopathic Medicine as named above. I, the undersigned, will rely on the Doctor to exercise judgment during the course of assessment and treatment, according to my best interests and the facts then known. I understand that my health records will be kept confidential, and not released to others unless so directed by myself or my representative, or unless it is required by law.

I further understand and am informed that, as in all health care, in the practice of Naturopathic Medicine, there are some very slight risks to treatment. These include, but are not limited to:

- Aggravation of pre-existing symptoms as in a healing crisis
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture or acupuncture
- Muscle strains, sprains or disc injuries from spinal manipulation

I do not expect the doctor to be able to anticipate and explain all risks and complications and wish to rely on the Doctor to exercise her best judgement during the course of the procedures.

I have been informed of the nature and purpose of Naturopathic treatments, the financial costs, expected benefits, potential risks and side effects, the likely consequences of not having/following the procedures, and alternative courses of action available to me.

I have read the above consent and have also had an opportunity to ask questions about its content. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures required for my health treatment. I intend this consent form to cover the entire course of diagnosis and treatment for my condition.

I understand that the medical practitioner endeavours to provide the best possible diagnosis and course of treatment. However, many factors will be important in determining actual results. Therefore, no representation or warranty is made with respect to any treatment, action or application of medical advice or information given.

Patient Name (please print): _____

Signature of Patient (or Guardian): _____

Date: _____