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# Pediatric Intake Form

Name: _____ Sex: M/F
D.O.B: _____ Age: _____
Parents Name: _____
Address: _____ City : _____
Postal code: _____
Email: _____ Contact No: _____
Occupation: _____ Pediatrician: _____

## HEALTH REVIEW

What are your main health concerns/ complaints regarding your child's health? (According to priority & duration)

_____
_____
_____
_____

When and how did this condition begin?

_____
_____

Has anything changed or worsened in the past 6 months?

_____
_____

Is the child receiving care from any health professionals?

_____

Has your child ever been diagnosed with an illness? Yes ☐ No ☐ If yes, please specify

_____
_____

Has your child ever been hospitalized? Yes ☐ No ☐ If yes, what reason?

_____

Has your child ever undergone any surgeries?

_____

Have your child experienced any major fall/ physical trauma? Please mention the incident and the age

_____
_____

**Please list any medications/ natural supplements that your child is currently taking**

| ***Medication/ Supplement*** | ***Dosage*** | ***How long/ How many round has the child taken?*** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Please describe ay concerns you may have regarding the child' s behavior, socialization skills or progress in school or daycare

_____

_____

_____

_____

**GENERAL HISTORY**

1. Please describe the circumstances of your child's birth. Yes ☐ No ☐ Jaundiced ☐ Blue Baby ☐

C-section ☐ Induced ☐ Forceps ☐ Vacuum ☐ Epidural ☐ Long labour ☐

_____

_____

2. Please describe the method(s) of feeding your child in infancy.

Breastfed:_____ duration _____

Bottle-fed: _____ duration_____ type of formula (milk/soy) _____

Problems?_____

_____

3. Did your child have any infections in early childhood? (i.e. chronic ear infections, tonsillitis, many colds/flu, etc.)

_____

_____

_____

_____

4. Does/has your child exhibit(ed) any of the following: Y / N

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Abdominal Pain | ☐ | Diarrhoea | ☐ | High fever | ☐ | Lack of confidence | ☐ | Phobia | ☐ |
| Bed wetting | ☐ | Dizzy spells | ☐ | Hives | ☐ | Leg cramps | ☐ | Parasites | ☐ |
| Bleeding gums | ☐ | Dry Skin | ☐ | Hyperactivity | ☐ | Migraines | ☐ | Sensitivity to light | ☐ |
| Blood in urine | ☐ | Eczema | ☐ | Itchy anus | ☐ | Motion sickness | ☐ | Teeth grinding | ☐ |
| Constipation | ☐ | Fatigue | ☐ | Itchy nose | ☐ | Nervousness | ☐ | Temper tantrums | ☐ |
| Dark circles | ☐ | Headache | ☐ | Jaundice | ☐ | Nightmares | ☐ | Weight loss/gain | ☐ |
| Defiance | ☐ | Heart murmur | ☐ | Joint pain | ☐ | Nose bleeds | ☐ | Vomiting | ☐ |

Comments:

_____

_____

5.a) Has your child received all routine vaccinations? Yes ☐ No ☐

DPT ☐ MMR ☐ Hib ☐ Polio ☐

b) Has your child received the following optional vaccines? Please state child's age.

Chicken Pox☐ Prevnar ☐ Hep B ☐ HPV ☐ Seasonal Flu ☐ H1N1 ☐

Other _____

c) Did your child show any reaction to his/her vaccinations? Explain.

_____

_____

_____

6. Has your child had dental work? i.e. fillings, anaesthetic. Please describe.

_____

_____

7. a) Has your child had x-rays? Explain. _____

8. Have you ever used pesticides on your lawn? Y/N _____

9. Have you purchased a new car, home, carpet or pet in the past year? Y/N When?

_____

_____

11. Has your child experienced any emotional trauma that you suspect may have affected his/her physical health? Y/N

_____

_____

**MOTHER'S HEALTH DURING PREGNANCY**

1. Did the mother suffer from any of the following conditions during pregnancy?

| | | | | | |
|---|---|---|---|---|---|
| Alcohol/ Cigarettes/ Drug Consumption | ☐ | Gestational diabetes | ☐ | Stress | ☐ |
| Anemia | ☐ | High Blood Pressure | ☐ | Thyroid problems | ☐ |
| Bleeding | ☐ | Nausea | ☐ | Uterine infection | ☐ |
| Dental problems | ☐ | Physical/ Emotional Trauma | ☐ | Others (please specify) | |
| Diabetes | ☐ | Pre-eclampsia | ☐ | | |

2. Was the mother taking any medications while pregnant? Yes ☐ No☐ If yes please specify

_____

_____

_____

3. Was the mother taking any medications while nursing? ? Yes ☐ No☐ If yes please specify

_____

_____

_____

**DIETARY REVIEW**

How many times does your child eat:

Main meals: _____ Times of the day: _____

Snacks: _____ Times of the day: _____

Do your child follow any dietary restrictions? Yes ☐ No If yes please specify _____

Dietary preference: vegan ☐ vegetarian ☐ meat eater ☐

How often does your child eat meat: daily ☐ 3-5/week ☐ 1/week or less ☐

How often does your child consume dairy products? daily ☐ 3-5/week ☐ 1/week or less ☐

What are your childs favorite foods? _____

How often does he/she eat them? _____

Does your child avoid certain foods? Yes ☐ No ☐ If so, please explain

_____

How many ½ cup servings of each does your child typically eat in a day?

_____Fruit: Fresh ☐ Dried ☐ Canned ☐

_____ Vegetables: Cooked ☐ Raw ☐

_____ Whole grains

_____ Protein: Types _____

_____ Dairy : Types _____

_____ Other: Specify _____

Does you child indulge in candies and sweets? Yes ☐ No ☐

How often? _____ times/ week How much?_____servings/day

How many teaspoons of sugar does your child have in a day? _____

**Please provide examples of your child's daily meals**:

Breakfast: _____

_____

Lunch: _____

_____

Supper: _____

_____

Snacks: _____

_____

Please circle the appropriate word and indicate how many cups of the following does your child drink per day

| | | | |
|---|---|---|---|
| Water: Tap/ Filtered/Bottled | | Vegetable juice: Fresh/ Boxed | |
| Cows Milk: skim, 1%, 2%,whole | | Pop: Regular/ Diet | |
| Fruit juice: Fresh/ Boxed | | Other | |

**Waiver of liability:**

I, the undersigned, hereby confirm that I am consulting with Manjiri Nadkarni, M.D.(Ayu.), R.H.N. , C.B.A.C. of my own free will. I understand that Manjiri Nadkarni is not a medical doctor and there will be no diagnosis made, no prescription given, but that she will offer an assessment of my general health and will make dietary, nutritional and supplemental recommendations to support my health. I understand the importance of frequent monitoring to revise the health protocol as required.

Signature of the Parent: _____Date: _____

Print Name: _____

***All case history notes and medical information recorded during the consultation are kept strictly confidential. Information contained herein will not be released to any person or agency except with your authorization or where required by law.***