Your Natural Path to Optimal Health & Wellbeing
ND
LEAT KUZNIAR, HBSc ND
Naturopathic Doctor
(201) 757-5558

Pediatric Intake

Today's date: _____

Child's name: _____ Date of birth: _____ Gender: M F

Who is filling out this form (name and relation)?:_____ _____

Contacts (in order of preference):

Name _____ Phone _____ h

Address _____ _____ w/c

_____ Email _____

_____ SSN _____

Relationship to child _____

Name _____ Phone _____ h

Address _____ _____ w/c

_____

_____

Relationship to child _____

Whom does the child live with? _____

Other health care providers:

1._____ 2._____ 3._____

Phone: (____) _____ Phone: (____) _____ Phone: (____) _____

What are your child's health concerns, in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Medical history

How would you describe your child's general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates:

_____

_____

_____

Which of the following has your child had? (n – never, m – mild, a – average, s – severe)

n m a s rubella (German measles)	n m a s roseola	n m a s impetigo
n m a s measles	n m a s scarlet fever	n m a s mononucleosis
n m a s chicken pox	n m a s whooping cough	n m a s ear infections
n m a s mumps	n m a s strep throat	

Does your child have any allergies (medicines, environmental, etc.)?

_____

_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

_____

_____

_____

How many times has your child been treated with antibiotics? ____ In the past year? _____

Please indicate which immunizations your child has received:

☐ DPT (diphtheria, pertussis, tetanus)	☐ Haemophilus influenza B	☐ Hepatitis B
☐ Tetanus booster; when? _____	☐ "Flu"	☐ Hepatitis A
☐ MMR (measles, mumps, rubella)	☐ Polio	

Other: _____

Please indicate any adverse reaction your child experienced in response to a vaccination:

_____

_____

What screening tests has your child had (blood, hearing, vision, etc.) _____

_____

Prenatal health

How would you describe the health of the parents at conception?

Mother Poor Fair Good Excellent Unknown

Father Poor Fair Good Excellent Unknown

How would you describe the health of the mother during the pregnancy?

Poor Fair Good Excellent Unknown

What was the mother's age at child's birth? _____

Did the mother receive prenatal medical care? Y N Unknown

Did the mother experience any of the following during the pregnancy:

☐ Bleeding ☐ High blood pressure ☐ Diabetes ☐ Thyroid problems

☐ Physical or emotional trauma

Other: _____

_____

Did the mother use any of the following during the pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational drugs: _____

☐ Prescription medications: _____

☐ Over-the-counter medications: _____

☐ Supplements: _____

☐ Other: _____

Was the mother exposed to significant second-hand smoke during pregnancy?: Y N

Birth history

Term length: ☐ Full ☐ Premature: _____ wks ☐ Late: _____ wks

Length of labour: _____ Weight at birth _____

Any complications? _____

Was the birth: Vaginal/C-section Induced Forceps Anesthesia used

Did the child experience any of the following at or shortly after birth?

☐ Jaundice ☐ Rashes ☐ Seizures ☐ Birth injuries_____

☐ Birth defects _____

☐ Other _____

Family history

Indicate whether a close relative (parent, sibling) has had any of the following

	Who?		**Who?**
Allergies		Diabetes	
Asthma		Kidney disease	
Birth defects		Autoimmune condition: (example: Lupus, RA, thyroid disease)	
Juvenile arthritis			

☐ I don't know the family medical history of the child

Do either of the parents have a chronic illness? Y N Please describe:

_____

Diet

How was your infant fed?

☐ Breast fed. How long?: _____ ☐ Formula. Milk/Soy/Other: _____

☐ Other: _____

What foods were introduced before 6 months? (Please list approximate month as well):

_____

_____

6–12 months?:

_____

_____

_____

Did your child ever experience colic?: Y N How severe? mild moderate severe

Does your child have any food allergies or intolerances? Please list:

_____

_____

_____

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)?:

_____

Describe a typical day's diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (type and amount) _____

Environment

Is the child in school daycare home care other : _____

What are your child's favorite activities? _____

_____

Does the child exercise regularly? Y N Please describe the type and frequency of physical activity:

_____

_____

How much television does your child watch? _____ hrs a day/week

How often does your child read (not for school), or How often does someone read to your child?

☐ Daily ☐ Several times a week ☐ Weekly ☐ Less than weekly

Does anyone in the child's household smoke? Y N

Are there animals in the home? Y N

Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)? Please describe:

_____

_____

_____

_____

How would you describe the emotional climate of the child's home?:

_____

_____

How would you describe your child's temperament?

_____

How would you describe your child's behavior in school/ daycare?:

_____

Is there anything that you feel is important that has not been covered?

_____

_____

_____

Please check all programs which you feel would be beneficial for your child:

Detoxification Program (diet, herbs, homeopathic remedies) ☐

Prevention Program (based on familial predispositions or current risk factors) ☐

Weight Loss/ Body Composition Program ☐

Exercise Program ☐

Healthy Eating Program ☐

Stress Management Program/ Biofeedback ☐

Testing for Vitamin/Mineral Deficiencies ☐

Organic Skincare Products ☐