BETA
WELLNESS CENTRE

Pediatric Intake Form

Today's Date _____
(Day/Months/Year)

Please help us to provide you with a complete evaluation by carefully filling out this questionnaire. All of your answers will be held absolutely confidential. If you have questions, please ask. Thank you.

Child's Name_____ **Birth Date (Day/Mo/Yr)**_____**Age**_____ **M○F○**

Home Address_____ **City** _____ **Postal Code** _____

Phone Number _____ **email**_____

Care Card Number_____

Mother's Name _____ **Father's Name** _____

Guardian's Name_____ **Relationship:**_____

Names of Other Healthcare Providers:
Naturopathic Physician_____
Medical Doctor_____
Chiropractor_____
Specialist_____
Other:_____

Number of visits to another Naturopathic Physician this year_____

ALLERGIC REACTIONS:

Medication	Environmental	Foods

Immunization History: Please check all that apply

☐**DPT** ☐**DP** ☐**Polio** ☐**Tetanus** ☐**MMR** ☐**Rubella** ☐**Hepatitis A/B** ☐**Influenza**

Reaction to vaccinations:_____

Current List of Medications and Supplements: _____
_____

CHILD'S HEALTH CONCERN(s) _____

_____

_____

When did the problem(s) begin (be specific)?_____

Has there been any diagnosis? If so, what?_____

What measures have you taken to improve the child's problem(s)?_____

SLEEPING HABITS:

During the first year of life _____

At the present time_____ **Naps**_____

Trouble falling asleep or waking in the night?_____

Bedwetting? _____

BEHAVIOR AND EMOTIONAL HISTORY:

Behavior among other children; behavior at home; relationship with other family members, siblings and friends:_____

_____

CHILDHOOD ILLNESSES:

Chicken pox_____
Measles _____
Mumps _____
Ear Infections _____
Frequent Colds_____

FAMILY MEDICAL HISTORY

Please indicate family member and mother's side (M) or father's side (F)

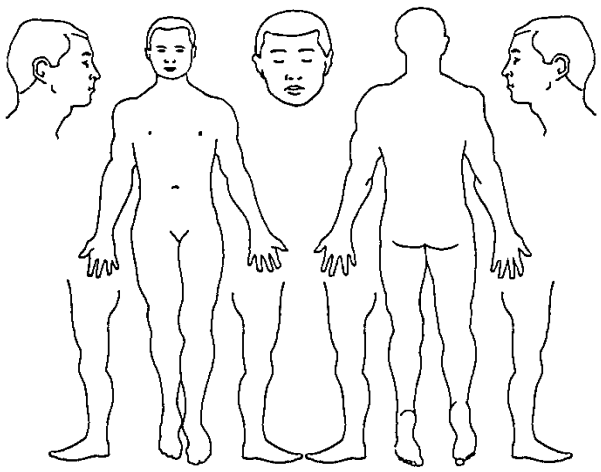
N/A	**Allergies**	N/A	**Asthma**	N/A	**Cancer**	N/A	**Diabetes**
N/A	**Heart Disease**	N/A	**High Blood Pressure**	N/A	**Seizures**	N/A	**Stroke**

DIET _____

Are you or have you ever been on a restricted diet? What kind?

Please describe your average daily diet:
Morning **Afternoon** **Evening**

INDICATE PAINFUL OR DISTRESSED AREAS



REVIEW OF SYSTEMS

CONDITION	Age of child	Location (if relevant)	Duration	Treatment
Diaper Rash				
Eczema				
Deformities of head shape				
Discharge from eyes				
Squint				
Ear Pain				
Nasal Discharge				
Mouth Sores				
Neck lumps				
Difficulty breathing				
Nausea/vomiting				
Diarrhea				
Constipation				
Dental caries				
Bed wetting				
Frequent urination				
Burning on urination				
Fractures				
Discharge from genitalia				
Growing pains				
Seizures				
Frequent colds and flus				
Asthma				

Patient's Parent/Guardian Name:_____ Date:_____

Signature_____