



E206 20159 88th Ave., Langley, BC V1M 0A4 • P: (604)881-7888 • F: (604)881-7889 • www.revivenaturopathic.com

PATIENT INTAKE FORM (PEDIATRIC, 6-12yrs)

Personal Information

(*all information in this form remains confidential and will be released only upon your written consent)

| | |
|------------------------------|------------------------|
| Last Name | First Name |
| Age | Gender M F |
| Date of Birth (mm/dd/yy) / / | Parent's Names |
| Address | |
| City | Province |
| Postal Code | Parent's Email Address |
| Home Phone | Parent's Work Phone |
| Family Physician | Phone |
| How did you Hear about us? | |

Please List all current health concerns in the order of importance

| | |
|----|----|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

Childhood Illnesses

- | | | |
|--|--|------------------------------------|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Strep Throat | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Other |

Immunizations (age given, any adverse reactions?)

- | | |
|--|--|
| <input type="checkbox"/> DPT (Diphtheria, Pertussis, Tetanus) | <input type="checkbox"/> HEP-B (Hepatitis B) |
| <input type="checkbox"/> HAEMOPHILUS INFLUENZA type B (Meningitis) | <input type="checkbox"/> MMR (Measles, Mumps, Rubella) |
| | <input type="checkbox"/> POLIO |

Breast fed? _____ how long? _____ Formula? _____ milk/soy _____

Known Allergies (including medicines, pollens, animals, foods & Chemicals)



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Sample Daily Diet (Choose a typical day and include food and liquids)

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Current Medications (including prescription & over the counter drugs, any supplements and herbs)

Has your child been treated with antibiotics? yes no

If yes, how many times: ____ Most recent date: _____

Please list any other past prescription medications: _____

What hospitalizations, surgeries or injuries has your child had?

How would you describe your child's temperament?

How would you describe your child's behavior and performance at school?

Review of Systems

Y = a condition now **P** = significant problem in the past **N** = never had

MENTAL/ EMOTIONAL

| | | | |
|---------------------|-------|---------------------|-------|
| Mood Swings | Y P N | Anxiety/nervousness | Y P N |
| Irritability | Y P N | Cries easily | Y P N |
| Hyperactivity | Y P N | Unusual fears | Y P N |
| Introvert/extrovert | Y P N | Sleep problems | Y P N |
| Motion/car sickness | Y P N | Nightmares | Y P N |

ENDOCRINE

| | | | |
|-----------------------|-------|---------|-------|
| Heat/cold intolerance | Y P N | Fatigue | Y P N |
|-----------------------|-------|---------|-------|



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| | | | |
|------------------|-------|------------------|-------|
| Excessive thirst | Y P N | Excessive hunger | Y P N |
| Low blood sugar | Y P N | High blood sugar | Y P N |

SKIN

| | | | |
|-------------|-------|---------------|-------|
| Rashes | Y P N | Eczema, Hives | Y P N |
| Acne, Boils | Y P N | Itching | Y P N |

HEAD

| | | | |
|--------------|-------|-------------|-------|
| Headaches | Y P N | Head Injury | Y P N |
| Dizzy spells | Y P N | High fevers | Y P N |

EYES

| | | | |
|---------------------|-------|--------------------|-------|
| Glasses or contacts | Y P N | Tearing or dryness | Y P N |
| Eye pain/strain | Y P N | | |

EARS

| | | | |
|----------|-------|------------------|-------|
| Earaches | Y P N | Impaired hearing | Y P N |
|----------|-------|------------------|-------|

NOSE AND SINUSES

| | | | |
|----------------|-------|---------------|-------|
| Frequent colds | Y P N | Nose Bleeds | Y P N |
| Stuffiness | Y P N | Hayfever | Y P N |
| Sinus problems | Y P N | Loss of smell | Y P N |

MOUTH AND THROAT

| | | | |
|----------------------|-------|--------------|-------|
| Frequent sore throat | Y P N | Canker sores | Y P N |
| Breath odor | Y P N | | |

RESPIRATORY

| | | | |
|--------|-------|------------|-------|
| Cough | Y P N | Wheezing | Y P N |
| Asthma | Y P N | Bronchitis | Y P N |

CARDIOVASCULAR

| | | | |
|---------------|-------|---------|-------|
| Heart disease | Y P N | Murmurs | Y P N |
|---------------|-------|---------|-------|

URINARY

| | | | |
|--------------------|-------|-------------|-------|
| Frequent urination | Y P N | Bed wetting | Y P N |
|--------------------|-------|-------------|-------|

GASTROINTESTINAL

| | | | |
|----------------------|-----------------|---------------|-------|
| Belching/passing gas | Y P N | Stomach aches | Y P N |
| Constipation | Y P N | Diarrhea | Y P N |
| Bowel Movements | How often _____ | | |

MUSCULOSKELETAL

| | | | |
|----------------------|-------|----------------------|-------|
| Joint pain/stiffness | Y P N | Muscle spasms/cramps | Y P N |
| Broken bones | Y P N | | |

BLOOD/PERIPHERAL VASCULAR

| | | | |
|--------|-------|------------------------|-------|
| Anemia | Y P N | Easy bleeding/bruising | Y P N |
|--------|-------|------------------------|-------|



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Family History: Include Blood Relatives Only

FATHER (age)* _____ MOTHER (age)* _____ BROTHERS (ages)* _____ SISTERS (ages)* _____

* If deceased, Please list age at death and circle.

IDENTIFY ALL FAMILY MEMBERS WHO HAVE EVER HAD ANY OF THE FOLLOWING (INDICATE FAMILY MEMBER BY F for FATHER, M for MOTHER, B1, B2, S1, etc.)

- | | | |
|--|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Colitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Birth Defects |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Does Patient have |
| Of _____ | <input type="checkbox"/> Thyroid Disorder | any of the above? |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Asthma | If Yes, Which Ones? |
| <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Eczema | _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney Disease | |

What expectations do you have for your child from working with our clinic?

Consent and Cancellation Policy

I, _____ hereby consent to receive treatment by the practitioners of Revive Naturopathic Health Clinic. I understand that I am responsible for paying the full cost of treatment at the time of appointment; including fees for the services, prescriptions, and laboratory tests. I understand that 24 hours notice is required for appointment cancellation; otherwise I will be responsible for the cancellation fee of \$30.

Signature: _____ Today's date: _____
(parent or guardian)

Thank you for your time in filling out this information.
We look forward to providing you with the highest quality of care for you and your child.