



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

PATIENT INTAKE FORM (PEDIATRIC, Birth-5yrs)

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 |

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

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

Please list any other past prescription medications: _____



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Patient's Medical History

Now Past

- | | | |
|---|---|---|
| <input type="checkbox"/> <input type="checkbox"/> Acne | <input type="checkbox"/> <input type="checkbox"/> Earaches | <input type="checkbox"/> <input type="checkbox"/> Learning Disorder |
| <input type="checkbox"/> <input type="checkbox"/> Allergies | <input type="checkbox"/> <input type="checkbox"/> Eczema | <input type="checkbox"/> <input type="checkbox"/> Moodiness |
| <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> <input type="checkbox"/> Stuffy Nose |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Exposure To: | <input type="checkbox"/> <input type="checkbox"/> Thrush |
| <input type="checkbox"/> <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> <input type="checkbox"/> Cigarette Smoke | <input type="checkbox"/> <input type="checkbox"/> Vomiting Spells |
| <input type="checkbox"/> <input type="checkbox"/> Birth Defects | <input type="checkbox"/> <input type="checkbox"/> Fatigue | <input type="checkbox"/> <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> <input type="checkbox"/> Colic | <input type="checkbox"/> <input type="checkbox"/> Frequent Infections | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Constipation | <input type="checkbox"/> <input type="checkbox"/> Headaches | <input type="checkbox"/> Surgeries (Year & Type) |
| <input type="checkbox"/> <input type="checkbox"/> Cough/Wheeze | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Cradle Cap | <input type="checkbox"/> <input type="checkbox"/> High Fever | <input type="checkbox"/> Hospitalization (Year) |
| <input type="checkbox"/> <input type="checkbox"/> Depression | <input type="checkbox"/> <input type="checkbox"/> Hyperactivity | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Diarrhea | <input type="checkbox"/> <input type="checkbox"/> Insomnia | <input type="checkbox"/> Injuries/Accidents(Year) |
| <input type="checkbox"/> <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> <input type="checkbox"/> Jaundice | _____ |

How would you describe your child's temperament? _____

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

Prenatal / Birth / Feeding History:

1. Mother's Health During The Pregnancy With This Patient Age _____

- | | | |
|--|--|--|
| <input type="checkbox"/> Alcohol Consumption | <input type="checkbox"/> Drugs | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Trauma/Injury | <input type="checkbox"/> High Blood Pressure |



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- Illness
- Stress
- Smoking
- X-Rays
- Toxemia
- Other _____
- Medications _____

- 2. Term Premature Full Birth Weight _____
- 3. Was Pregnancy/ Birth Easy? Difficult? C-Section?
- 4. Feeding of Infant
 - Breast Fed How Long? _____ Cow's Milk? _____
 - Formula Fed How Long? _____ Type of Formula _____
 - Age solid Foods Begun _____ What Foods? _____
 - Any Food Allergies or Intolerances? To What Foods? _____
- 5. Sample Daily Diet (Choose a typical day and include food and liquids)

Social History

- Parents: Married Separated Divorced
 - Mother's Occupation _____ Full Time Part Time
 - Father's Occupation _____ Full Time Part Time
- 2. Other Guardian: _____ Relationship _____
- 3. Others Residing In Home _____ Relationship _____
- 4. Daycare/Preschool/School: How Many Hours Each Day? _____
How Many Days Of The Week? _____
- 5. Interaction with Relatives: Who? _____
How Often? _____

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.