NATUROPATHIC HEALTH CLINIC

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 ☑

- ☐ Chicken Pox
- ☐ Scarlet Fever
- ☐ Mononucleosis
- ☐ Measles
- ☐ Rheumatic Fever
- ☐ Ear Infections
- ☐ Strep Throat
- ☐ Tonsillitis
- ☐ Rubella
- ☐ Mumps
- ☐ Pneumonia
- ☐ Other

Immunizations ☑ (age given, any adverse reactions?)

- ☐ DPT (Diptheria, Pertussis, Tetanus)
- ☐ HAEMOPHILUS INFLUENZA type B (Meningitis)
- ☐ HEP-B (Hepatitis B)
- ☐ MMR (Measles, Mumps, Rubella)
- ☐ 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.)

- ☐ Alcoholism
- ☐ Bleeding Disorder
- ☐ Heart Disease
- ☐ Obesity
- ☐ Allergies
- ☐ Cancer Of_____
- ☐ Hearing Loss
- ☐ Stomach Ulcers
- ☐ Anemia
- ☐ Colitis
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Arthritis
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Thyroid Disorder
- ☐ Asthma
- ☐ Eczema
- ☐ Kidney Disease
- ☐ Tuberculosis
- ☐ Birth Defects
- ☐ Epilepsy
- ☐ Mental Illness
- ☐ Other_____
- ☐ Does Patient have any of the above? If Yes, Which Ones? _____

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.