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 ☑

- ☐ 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

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: _____

NATUROPATHIC HEALTH CLINIC

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Patient's Medical History ☑

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

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

Prenatal / Birth / Feeding History:

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

☐ Alcohol Consumption	☐ Drugs	☐ Nausea
☐ Bleeding	☐ Trauma/Injury	☐ High Blood Pressure

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

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.