Sussanna Czeranko, ND

Manitou Waters Naturopathic Clinic

Date:______________________

PEDIATRIC INTAKE

Child's Name: ________________________ Age: _____ Sex: _____ Birthdate: ___ /___ /____
(M) (D) (Y)

Parent's Name: ___________________________

Address: ________________________________ Parents Phone (home/cell): ____________________

_______________________________________ (work): _________________________

Who referred you to this office? ____

What is your chief concern about your child's health? ____

____

____

Who diagnosed the ailment? your pediatrician ______ a specialist ______ other _________________

What else would you like to see changed in his / her health? __________________________________

What was the level of health of both parents prior to conception?

Father: poor _________ fair _________ good __________ excellent __________

Mother: poor _________ fair _________ good __________ excellent __________

What was the level of health of the mother during the pregnancy?

Poor __________ fair _________ good _________ excellent __________

Comments: ____

What supplements did you take during your pregnancy? _______________________________________

____

Did you smoke during pregnancy? Yes No Did you drink alcohol during your pregnancy? Yes No

What medications were you on during pregnancy?

Prescribed ____

Over the counter ____

How was the birth of this child? Indicate if there were any complications. ________________________

____

Was the baby nursed after birth? Yes ____ No ____ If yes, for how long? ________________________

If no, what kind of formula was used? ____

Did your baby have colic? Never _____ occasionally ______ often ______ severe ________

What vaccinations has your child had?

- ☐ Measles, Mumps, Rubella ☐ Influenza ☐ Hepatitis
- ☐ Diphtheria, Pertussis, Tetanus ☐ Polio ☐ Flu shot

Others ____

What childhood diseases has your child had?

☐ Chickenpox	☐ Scarlet Fever	☐ Pneumonia	☐ Measles
☐ Mumps	☐ Rubella	☐ Rheumatic Fever	☐ Pertussis
☐ Tonsillitis	☐ Ear infections	☐ Frequent Colds	☐ Allergies
☐ Impetigo	☐ Strept Throat	☐ Mononucleosis	

☐ Other:____

How many times has your child been treated with antibiotics? _________________________________

List the medications that your child has taken in the past and in the present? ____________________

____

____

Indicate if your child has had any of the following symptoms?

Use checkmark (✓) if current, and P if past symptom.

☐ eczema	☐ nosebleeds	☐ nervous	☐ easy bruising	☐ cries easily
☐ skin rash	☐ night sweats	☐ nightmare	☐ sleeping problems	☐ bed wetting
☐ diarrhea	☐ constipation	☐ bad breath	☐ stomach ache	☐ vomiting
☐ fatigue	☐ unusual fears	☐ body odour	☐ hearing loss	☐ blood in urine

How is your child's behaviour and performance at school ? ____________________________

____

Are this child's natural parents: Married; Common law; Separated; Divorced; Remarried

Are there brothers and / or sisters?

Name	Age	State of Health

What is the emotional climate of the child's home presently?

☐ very stable ☐ stable ☐ stressful ☐ very stressful

FAMILY HEALTH HISTORY: Indicate if there have been any of the following diseases in Grandparents, parents, or siblings.

☐ Allergies	☐ Arthritis	☐ Birth Defects	☐ Cancer
☐ Diabetes	☐ Heart Disease	☐ Hypertension	☐ Mental Disease
☐ Tuberculosis	☐ Asthma	☐ Skin disease	☐ Learning disability
☐ Food allergies	☐ Anemia	☐ Frequent colds	☐ Stomach disorders