



PEDIATRIC INTAKE FORM
CALGARY CENTRE FOR NATUROPATHIC MEDICINE
PH: (403) 270 - 9355 200, 110 Point McKay Cres. NW, Calgary, AB T3B 5B4
www.calgarynaturopathic.com

This intake is designed to be filled in by the parent or caregiver of a child less than 12 years of age.
The information is critical for the doctors at CCNM to give the best care possible to the child.

Name: _____ Date: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Telephone: (Home) _____ (Parent's work): _____

Parent's e-mail address: _____

Child's Age: ____ Date of Birth: _____ Gender: Female ____ Male ____

Child resides with: Parents ____ Siblings ____ Other ____

How did you hear about CCNM? _____

Have you any family members that are patients at CCNM? _____

Name of next of kin or other to contact in an emergency: _____

Relationship to you: _____ Phone # _____

Address: _____

To treat differently, you must think differently!



CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will go along way in assisting our understanding of your truest desires for your child. Your time, thoughtfulness and honesty in completing this overview will greatly aid us to assist your child's health needs.

Why did you choose to come to CCNM?

What do you know of our approach to wellness?

What three (3) expectations do you have from this visit?

1. _____
2. _____
3. _____

What long term expectations do you have of your CCNM doctor? _____

What is your present level of commitment of the child and the family to address any underlying causes and signs/symptoms that relate to lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

0% 1 2 3 4 5 6 7 8 9 10 100%

What behaviours / habits does the family currently engage in regularly that you believe support health? (Please list) _____

What behaviours / habits does the family currently engage in regularly that you believe are undermining positive lifestyle? (Please list) _____

What potential obstacles do you foresee in addressing the lifestyle factors which are challenging the child's health and in adhering to the therapeutic protocols which I will be sharing with you?

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes the child and the family will be making?

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Is the child currently receiving health care? **Y** **N** If yes, where and from whom:

If no, when and where did they last receive medical or health care? _____

What was the reason? _____

What are the most important health problems? List as many as you can in order of importance:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____

Do they have any known contagious diseases at this time? **Y** **N**

If yes, what? _____

FAMILY HISTORY

Does the child have a family history of any of the following? *(Please circle all that apply)*

- | | | | |
|----------------|-----------|---------------|---------------------|
| Cancer | Diabetes | Heart Disease | High Blood Pressure |
| Kidney Disease | Epilepsy | Arthritis | Glaucoma |
| Tuberculosis | Stroke | Anaemia | Mental Illness |
| Asthma | Hay Fever | Hives | |

Any other relevant family history? _____

What is the child's heritage: **German** _____ **Nordic** _____ **Celtic** _____ **Other** _____

CHILDHOOD ILLNESSES *(Please circle all that apply)*

- | | | |
|---------------|------------|-----------------|
| Scarlet Fever | Diphtheria | Rheumatic Fever |
| Mumps | Measles | German Measles |

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HOSPITALIZATION, SURGERY, IMAGING

What hospitalizations, surgeries, X-Rays, CAT Scans, EEG, EKG's have they had?

	Year		Year		Year	
	Year		Year		Year	
	Year		Year		Year	

ALLERGIES

Are the child hypersensitive or allergic to any drugs? _____

Any foods? _____

Any environmental influences or chemicals? _____

CURRENT MEDICATIONS

Are they currently taking or using any of the following?

Laxatives	Y	N	Pain relievers	Y	N	Antacids	Y	N
Cortisone	Y	N	Appetite suppressants	Y	N	Antibiotics	Y	N
Tranquilizers	Y	N	Thyroid medication	Y	N	Sleeping Pills	Y	N

Please list any prescription and OTC medications, vitamins or other supplements they are taking:

GENERAL

Height: _____ Weight: _____ lbs. Weight 1 year ago: _____ lbs.

Maximum Weight: _____ When: _____

When during the day are they happiest? _____ grumpiest? _____

TYPICAL FOOD INTAKE

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

HABITS

Main interests and hobbies? _____

Physical activity? Y N

If yes, what kind? _____ How often? _____

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FOR THE FOLLOWING, PLEASE CIRCLE

Y = A condition you have now N = Never had P = Significant problem in the past

Watch television? Y N How many hours? _____ Read? Y N How many hours? _____

Average 6 - 8 hours of sleep daily	Y	N	Spend time outside	Y	N	
Sleep well	Y	N	Drink cola /other pop	Y	N	P
Awaken rested	Y	N	Add salt to food	Y	N	P
Have they a history of abuse	Y	N	Drink or eat refined sugar	Y	N	P
Experienced major traumas	Y	N	P			

REVIEW OF SYSTEMS

Mental / Emotional					
Slow to reach developmental milestones	Y	N	P	Poor concentration, memory	Y N P
Mood Swings	Y	N	P	Anxiety or nervousness	Y N P
Immune & Endocrine					
Reactions to immunizations	Y	N	P	Recurrent infections	Y N P
Chronically swollen glands	Y	N	P	Slow wound healing	Y N P
Hypoglycaemia	Y	N	P	Diabetes	Y N P
Neurologic & Musculoskeletal					
Seizures	Y	N	P	Paralysis	Y N P
Muscle weakness or cramping	Y	N	P	Numbness or tingling	Y N P
Loss of memory	Y	N	P	Loss of balance	Y N P
Skin					
Rashes	Y	N	P	Eczema or Hives	Y N P
Acne or boils	Y	N	P	Itching	Y N P
Colour change	Y	N	P	Impetigo	Y N P
Head, Eyes & Ears					
Headaches	Y	N	P	Head Injury	Y N P
Impaired vision	Y	N	P	Glasses or contacts	Y N P
Colour blindness	Y	N	P	Impaired hearing	Y N P
Earaches	Y	N	P	Frequent colds	Y N P
Nose bleeds	Y	N	P	Stuffiness	Y N P
Hay fever	Y	N	P	Sinus problems	Y N P
Loss of smell	Y	N	P	Frequent sore throat	Y N P
Copious saliva or drooling	Y	N	P	Teeth grinding	Y N P
Dental Cavities					

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Respiratory & Cardiovascular

Asthma	Y	N	P	Bronchitis	Y	N	P
Pneumonia	Y	N	P	Wheezing	Y	N	P
Murmurs	Y	N	P	Fainting	Y	N	P

Gastrointestinal

Trouble swallowing	Y	N	P	Abdominal pain or cramps	Y	N	P
Change in appetite	Y	N	P	Belching or passing gas	Y	N	P
Nausea / vomiting	Y	N	P	Constipation	Y	N	P
Canker Sores	Y	N	P	Constipation	Y	N	P
Jaundice (yellow skin)	Y	N	P	Bowel Movements: How often? _____			
Blood, mucus or undigested food in stools	Y	N	P	Is this a change? _____			

Urinary

Pain on urination	Y	N	P	Frequent infections	Y	N	P
Bedwetting	Y	N	P				

Is there anything else you would like to add or comment on?

Cancellation Policy:

We will call to confirm 48 - 72 hours prior to your scheduled appointment, and we require a return confirmation phone call from you.

Appointments cancelled with less than 24 hours notice may be charged \$35. Appointments cancelled the same day or missed appointments will be charged the full appointment fee.

I understand and agree: _____ Date: _____
Signature

Thank you for your time and effort.

We at CCNM look forward to providing you with the best possible care!

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