PEDIATRIC INTAKE FORM

CYNDI GILBERT
NATUROPATHIC DOCTOR

PERSONAL & CONTACT INFORMATION

NAME: _____ ADDRESS: _____

GENDER: _____ ASSIGNED SEX: _____

AGE: _____ DATE OF BIRTH: (YY/MM/DD) _____ HEIGHT: _____ WEIGHT: _____

PARENT/GUARDIAN: _____ PARENT/GUARDIAN: _____

PHONE 1 _____ PHONE 2 _____ PHONE 1 _____ PHONE 2 _____

EMAIL: _____ EMAIL: _____

OTHER HEALTH CARE PROVIDERS – *Please put a * beside the name of the child's primary practitioner*

NAME: _____ SPECIALTY: _____ PHONE: _____

NAME: _____ SPECIALTY: _____ PHONE: _____

HOW DID YOU HEAR ABOUT ME?

WHAT ARE YOUR TOP CONCERNS ABOUT YOUR CHILD'S HEALTH?

1) 2) 3)

MEDICAL HISTORY – *Hospitalizations / Injuries / Major Illnesses*

REASON / INJURY / ILLNESS	DATE	OUTCOME

VACCINATION HISTORY

AS PER ONTARIO SCHEDULE? ☐ ALTERNATE SCHEDULE? ☐ IF YES, PLEASE DESCRIBE: _____

ANY VACCINES DECLINED? ☐ IF YES, PLEASE LIST: _____

ANY ADVERSE REACTIONS? _____

CURRENT MEDICATIONS & SUPPLEMENTS

NAME	DOSE	REASON FOR TAKING	SIDE EFFECTS

166 Montrose Ave., Toronto ON, M6J 2T8 • **T:** 416.817.2385 **F:** 416.536.5063 • cyndi@cyndigilbert.ca • www.cyndigilbert.ca

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FAMILY HISTORY – *Please list if anyone in the child's biological family (parents, siblings, grandparents, aunts/uncles) has or has had any of the following. If you do not have information about the biological family's medical history, please skip.*

	FAMILY MEMBER		FAMILY MEMBER
ALCOHOLISM/DRUG ABUSE		DIGESTIVE CONDITION	
ALLERGIES/HAY FEVER		HEART DISEASE	
ARTHRITIS		MENTAL HEALTH CONDITION	
ASTHMA/EMPHYSEMA		OVERWEIGHT/OBESITY	
AUTO-IMMUNE CONDITION		SKIN DISEASE	
CANCER		THYROID DISEASE	
DIABETES		OTHER:	

PRENATAL HISTORY – *If known*

PARENTS'/SURROGATE'S PHYSICAL AND EMOTIONAL HEALTH DURING PREGNANCY:

MEDICAL INTERVENTIONS (E.G. FERTILITY DRUGS/PROCEDURES, AMNIOCENTESIS):

DURATION OF PREGNANCY: PRENATAL CARE:

COMPLICATIONS? OTHER ILLNESSES/INFECTIONS:

HOW MUCH ALCOHOL? TOBACCO? RECREATIONAL DRUGS?

THE BIRTH EXPERIENCE – *If known*

LENGTH OF LABOUR: LOCATION OF BIRTH: NATAL SUPPORT:

DELIVERY: PREMATURE ☐ ON TIME ☐ LATE ☐ INDUCED ☐ VAGINAL ☐ BREECH ☐ C-SECTION ☐

MEDICATIONS/INSTRUMENTATION (E.G. FORCEPS, SUCTION) USED:

COMPLICATIONS DURING DELIVERY?

NEONATAL HISTORY

BIRTH WEIGHT: AGPAR SCORE (IF KNOWN):

INTERVENTIONS AT BIRTH (E.G. VITAMIN K, ANTIBIOTIC EYE DROPS):

COMPLICATIONS AFTER BIRTH?

FEEDING: BREAST/CHEST FED ☐ FORMULA FED ☐ HOW LONG (MONTHS/YEARS)?

SOCIAL HISTORY & LIFESTYLE – *Please explain any concerns you or your child have in the following areas:*

APPEARANCE / HEIGHT / WEIGHT

BEHAVIOUR / MOODS / SLEEP

FAMILY/FRIENDS

GRADES / LEARNING ABILITIES

COMPUTER / TV / VIDEO GAME USE

DIETARY RESTRICTIONS (E.G. RELIGIOUS, VEGETARIAN)?

DOES YOUR CHILD EXERCISE? IF YES, WHAT FORMS? HOW OFTEN?

DO YOU HAVE REASON TO BELIEVE THAT YOUR CHILD IS BEING OR HAS EVER BEEN PHYSICALLY, EMOTIONALLY, OR SEXUALLY ABUSED? ☐

IF YES, PLEASE PROVIDE DETAILS:

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