NATURAL BALANCE
HEALTH CLINIC

Pediatric Intake Form

Patient information

First and last name ______________________________

Date of birth (D/M/Y) ____________ Age __________ Gender ☐M ☐F

Height ______________ Weight ______________

Names of parents / guardians ______________________________

Address ______________________________

City ______________ Province __________ Postal Code __________

E-mail ______________________________

Phone numbers Home __________ Work __________ Cell __________

Emergency contact

Name ______________ Relation ______________

Phone numbers Home __________ Work __________ Cell __________

Patient's primary care physician / pediatrician ______________________________

Phone number __________ Address ______________________________

Person completing this form ______________________________

Relation ______________________________

How did you hear about our clinic? ______________________________

Were you referred to our office? ☐ Y ☐ N If yes, by whom? ______________________________

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Medical history

Purpose of the visit to our office?

____

____

How long has you child been experiencing this?

____

____

Other health care providers consulted

____

____

Treatments previously tried

____

____

Please list any other Health Concerns with your child

____

____

____

Please indicate if your child has experienced any of the following conditions currently or in the past

Condition			Condition		
Measles	☐Current	☐Past	Seizures	☐Current	☐Past
Chicken Pox	☐Current	☐Past	Scarlet Fever	☐Current	☐Past
Mononucleosis	☐Current	☐Past	Colic / gas / cramping	☐Current	☐Past
Mumps	☐Current	☐Past	Diarrhea	☐Current	☐Past
Ear infections	☐Current	☐Past	Digestive difficulties	☐Current	☐Past
Pneumonia	☐Current	☐Past	Constipation	☐Current	☐Past
Headaches	☐Current	☐Past	Frequent colds	☐Current	☐Past
ADD / ADHD	☐Current	☐Past	Coughing / wheezing	☐Current	☐Past
Rubella	☐Current	☐Past	Sinus problems	☐Current	☐Past
Asthma	☐Current	☐Past	Cold sores	☐Current	☐Past
Hives / rashes /eczema	☐Current	☐Past	Strep throat / tonsillitis	☐Current	☐Past
Allergies	☐Current	☐Past	Chronic runny nose	☐Current	☐Past
Hay Fever	☐Current	☐Past	Anxiety	☐Current	☐Past
Temper tantrums	☐Current	☐Past	Bed wetting	☐Current	☐Past

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Vaccination history

Please check the box beside the vaccinations your child has received. Provide the appropriate dates.

	date
☐ Diptheria	______________
☐ Pertussis	______________
☐ Tetanus	______________
☐ Polio	______________
☐ Hemophilus Influenza B	______________
☐ Measles	______________
☐ Mumps	______________
☐ Rubella	______________
☐ Hepatitis B	______________
☐ Chicken Pox	______________

Did your child experience any adverse reactions to these vaccines? ☐ Y ☐ N

If so, please indicate which ones

____

____

Please list any current medications/supplements

____

____

Please list any past medications/supplements

____

____

Please list any allergies (environmental, food, medications)

____

____

Please list any past surgeries or hospitalizations, including dates and reason why

____

____

____

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Diet

Do you have any food allergies or intolerances?

____

____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

____

____

Describe a typical day's diet:

Breakfast ______________________________

Lunch ______________________________

Dinner ______________________________

Snacks ______________________________

Beverages (and total quantity) ______________________________

Family history

	Family member		Family member
Cancer		Autoimmune disease	
Heart disease		Allergies	
Diabetes		Alcoholism	
Tuberculosis		Congenital conditions	
Depression / anxiety		Genetic abnormalities	
Mental illness		Bleeding disorders	

Prenatal history

Name of the midwife/Obstetrician/health care provider

____

What was the health of the parents at the time of the conception?

Mother	☐ Poor	☐ Fair	☐ Good	☐ Excellent	☐ Unknown
Father	☐ Poor	☐ Fair	☐ Good	☐ Excellent	☐ Unknown

Email completed form to info@naturalbalancehealthclinic.com or print and bring to your appointment