



Dr. Han Ping Helen Cen, ND 201, 8135 102 St. Edmonton, AB, T6E 4A4  
www.drcennd.ca 780-414-1466

## Pediatric (birth-15 years) Intake Form

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Current weight: \_\_\_\_\_ Height: \_\_\_\_\_

Who is filling out this form? (Name and relationship) \_\_\_\_\_

Contacts:

Name: \_\_\_\_\_ Phone (Primary): \_\_\_\_\_

Address: \_\_\_\_\_ (Other): \_\_\_\_\_

\_\_\_\_\_  
Email: \_\_\_\_\_

\_\_\_\_\_  
Relation: \_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you received *naturopathic* care previously? \_\_\_\_\_

If so, when? \_\_\_\_\_ Name of Practitioner: \_\_\_\_\_

For what reason? \_\_\_\_\_

How did you hear of us/who were you referred by: \_\_\_\_\_

*This is a confidential record of your medical history and will be kept in this office. Information contained in it will not be released to any person unless authorized by you.*

I AGREE to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, cost of laboratory tests, administrative fees, missed appointment fees as well as other applicable fees. A receipt will be provided for your private insurance coverage and/or income tax purposes.

Patient's Full Name: \_\_\_\_\_ Date of Consent: \_\_\_\_\_

Signature of Patient or Lawful Representative: \_\_\_\_\_

### Health Concerns

What are the child's health concerns, in order of importance?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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## Vitamins and Supplements

Please list all vitamin/mineral/herbal supplements your child is currently taking:

**\*\*Please bring in all supplements info (or photo) to initial visit\*\***

Supplement (including brand)	Dosage	When did you begin this supplement?

## Medication

Please list all prescription and non-prescription medications your child is currently taking:

**\*\* Please bring in all medications to initial visit\*\***

Medication	Dosage	When did you begin this medication?

Please list all prescription medications your child has taken in the past for longer than six months. Indicate how long your child took each medication.

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## Family History

Is there a history of any of the following in the family? Please check and then list relationship of family member beside the condition.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Depression          | <input type="checkbox"/> Celiac           |
| <input type="checkbox"/> Allergies        | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Colitis          |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Schizophrenia    |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Hyperactivity       | <input type="checkbox"/> Yeast Infections |
| <input type="checkbox"/> Bed Wetting      | <input type="checkbox"/> Kidney Disease      |   |
| <input type="checkbox"/> Candida Albicans | <input type="checkbox"/> Learning Disability |   |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Mental Disease      |   |
| <input type="checkbox"/> Cataracts        | <input type="checkbox"/> Multiple Sclerosis  |   |



## Medical History

Please list any serious conditions, injuries and/or major surgery your child has had and when they occurred.

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All allergies/intolerances/sensitivities:

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Which of the following has your child had? (n = never m = mild a = average s = severe)

<b>n m a s</b> rubella (german measles)	<b>n m a s</b> roseola	<b>n m a s</b> impetigo
<b>n m a s</b> measles	<b>n m a s</b> scarlet fever	<b>n m a s</b> mononucleosis
<b>n m a s</b> chicken pox	<b>n m a s</b> whooping cough	<b>n m a s</b> ear infections
<b>n m a s</b> mumps	<b>n m a s</b> strep throat	

## Vaccinations (please check)

- |   |                                      |
|---|--------------------------------------|
| <input type="checkbox"/> DPT (Diphtheria, Pertussis, Tetanus) | <input type="checkbox"/> Flu Shot    |
| <input type="checkbox"/> MMR (Measles, Mumps, Rubella)        | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Chicken Pox                          | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Polio                                | <input type="checkbox"/> Other       |

Did your child experience any adverse reactions from them? If yes, please explain.

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## PRENATAL HEALTH

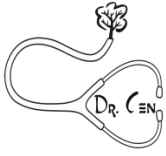
1. What was the health of the parents at conception?

- Mother:  Poor  Fair  Good  Excellent  
 Unknown
- Father:  Poor  Fair  Good  Excellent  
 Unknown

2. What was the health of the mother during the pregnancy?

- Poor  Fair  Good  Excellent  Unknown

3. What was the mother's age at child's birth? \_\_\_\_\_



4. How was the mother's diet during pregnancy?

- Poor       Fair       Good       Excellent       Unknown

5. Did the mother receive prenatal medical care?       Y       N       Unknown

6. Did the mother experience any of the following during the pregnancy:

Bleeding       High blood pressure       Nausea       Vomiting

Diabetes       Thyroid problems       Physical or emotional trauma

Other

Did the mother use any of the following during the pregnancy?

Tobacco       Alcohol       Recreational drugs: \_\_\_\_\_

Prescription medications: \_\_\_\_\_

Over-the-counter medications: \_\_\_\_\_

Supplements: \_\_\_\_\_

## BIRTH HISTORY

Term length:  Full       Premature: \_\_\_\_\_ wks       Late: \_\_\_\_\_ wks

Length of labour: \_\_\_\_\_ Weight at birth \_\_\_\_\_

Any complications? \_\_\_\_\_

Was the birth:  Vaginal       C-section       Induced       Forceps       Anaesthesia used

Did the child experience any of the following at or shortly after birth?

Jaundice       Rashes       Seizures       Birth Injuries: \_\_\_\_\_

Birth defects \_\_\_\_\_

Other \_\_\_\_\_

At what age did your child first;

Sit up \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_ Talk \_\_\_\_\_

## DIET

How was your infant fed?  Breast fed and how long? \_\_\_\_\_  Formula/Milk/Soy/Other: \_\_\_\_\_

Other: \_\_\_\_\_

What foods were introduced before 6 months? (Please list approximate month as well.)

6-12 months?

Did your child ever experience colic?  Y  N How severe?  mild  moderate  severe

**Thank you for taking the time to complete this form to your best knowledge.**