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.

_____

_____

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.

- ☐ Alcoholism
- ☐ Allergies
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bed Wetting
- ☐ Candida Albicans
- ☐ Cancer
- ☐ Cataracts
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Hyperactivity
- ☐ Kidney Disease
- ☐ Learning Disability
- ☐ Mental Disease
- ☐ Multiple Sclerosis
- ☐ Celiac
- ☐ Colitis
- ☐ Schizophrenia
- ☐ Tuberculosis
- ☐ Yeast Infections

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Medical History

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

_____

_____

_____

_____

All allergies/intolerances/sensitivities:

_____

_____

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

n m a s rubella (german measles)
n m a s measles
n m a s chicken pox
n m a s mumps
n m a s roseola
n m a s scarlet fever
n m a s whooping cough
n m a s strepthroat
n m a s impetigo
n m a s mononucleosis
n m a s ear infections

Vaccinations (please check)

- ○ DPT (Diphtheria, Pertussis, Tetanus)
- ○ MMR (Measles, Mumps, Rubella)
- ○ Chicken Pox
- ○ Polio
- ○ Flu Shot
- ○ Hepatitis A
- ○ Hepatitis B
- ○ Other

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

_____

_____

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? _____

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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.