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**CONFIDENTAL PEDIATRIC INTAKE FORM (0-12 years)**

**for Naturopathy Consultation with Dr Taylor Bean**

Thank you for taking the time to complete this intake form to the best of your ability. This is an important step towards defining your child’s health care needs. Please be honest with your answers, as this will help me achieve a more suitable treatment plan for your child.

Everything that is share with me both by you and your child is **absolutely confidential.**

**Patient Information** **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_ Gender: \_\_\_\_

Date of Birth: (D) \_\_\_\_\_\_ (M)\_\_\_\_\_\_\_ (Y) \_\_\_\_\_\_\_\_

**Parent Information**

Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home /Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Post code: \_\_\_\_\_\_\_

Nationality: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about Dr. Bean?

☐ Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Friend/Colleague \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Family/Relative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we leave messages relating to your child's visits? □ Yes □ No

Person to contact in case of an emergency (please include their contact number and relation to you): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Present Health Concerns**

|  |  |
| --- | --- |
| **Major Health Concerns (in order of priority)** | **What treatments have been used for these concerns?** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

List any **diagnoses** received for any of your child's medical concerns (including who provided the diagnosis):

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies** (food, drugs, environmental) and reactions:

1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications:** **Supplements:**

NOW PAST

Aspirin \_\_\_\_\_ \_\_\_\_

Panadol \_\_\_\_\_ \_\_\_\_

Antibiotics \_\_\_\_\_ \_\_\_\_

Other\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_

|  |  |
| --- | --- |
| Name of Supplement | How much is your child taking? |
|  |  |
|  |  |
|  |  |

**Childhood illnesses:**

\_\_ chicken pox \_\_ scarlet fever \_\_ mononucleosis

\_\_ red measles \_\_ rheumatic fever \_\_ ear infection(s)

\_\_ mumps \_\_ strep throat \_\_ tonsillitis

\_\_ rubella \_\_ pneumonia \_\_ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vaccination history – write ‘YES’ if your child has received the vaccine. Please list if they had a reaction to the vaccine**

1. Hepatitis A and B: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. DPT + IPV + HIB (month 3,4,5) \_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_

3. MMR (Measles, Mumps, Rubella ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. PCV \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Chicken pox \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Flu vaccine (how many have you had) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Polio \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### 8. BCG \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. OPV

10. Rotovirus

**Surgeries and hospitalizations** (include year):

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

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**Mother's health during pregnancy:**

Age at pregnancy :\_\_\_\_\_\_\_\_\_

Any Underlying diseases during pregnancy:

□ Alcohol

□ Medications

□ Bleeding

□ Stress

□ Cigarettes

□ Toxemia

□ Diabetes

□ Trauma/injury

□ Drugs

□ X-rays

□ Extreme nausea

□ High blood pressure

□ Illness

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

**Infant feeding:**

□ Breast fed Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Formula fed Duration:\_\_\_\_\_\_\_Type:\_\_\_\_\_\_\_\_\_\_\_

Age solids began:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What foods are they eating:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food allergy/intolerances:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sample daily diet:** choose a typical day, include liquids

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

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#### Family History

Check mark if the following are in the family. Please write which family member has it:

\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ alcoholism \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ allergies

\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ anemia \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ arthritis

\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ asthma \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ diabetes

\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ eczema \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ epilepsy

\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ heart disease \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hearing loss

\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_hypoglycemia \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ mental illness

\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ obesity \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ stroke

\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ thyroid disorder \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cancer (what type)

\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ kidney disease

#### Patient’s Health History

Now Past Never Now Past Never

\_\_\_\_ \_\_\_\_ \_\_\_\_\_ allergies \_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ fatigue

\_\_\_\_ \_\_\_\_ \_\_\_\_\_ anemia \_\_\_\_ \_\_\_\_ \_\_\_\_\_ frequent infections

\_\_\_\_ \_\_\_\_ \_\_\_\_\_ asthma \_\_\_\_ \_\_\_\_ \_\_\_\_\_ headaches

\_\_\_\_ \_\_\_\_ \_\_\_\_\_ bedwetting \_\_\_\_ \_\_\_\_ \_\_\_\_\_ heart murmur

\_\_\_\_ \_\_\_\_ \_\_\_\_\_ birth defects \_\_\_\_ \_\_\_\_ \_\_\_\_\_ high fever

\_\_\_\_ \_\_\_\_ \_\_\_\_\_ colic \_\_\_\_ \_\_\_\_ \_\_\_\_\_ hyperactivity

\_\_\_\_ \_\_\_\_ \_\_\_\_\_ cough/wheeze \_\_\_\_ \_\_\_\_ \_\_\_\_\_ insomnia

\_\_\_\_ \_\_\_\_ \_\_\_\_\_ croup \_\_\_\_ \_\_\_\_ \_\_\_\_\_ jaundice

\_\_\_\_ \_\_\_\_ \_\_\_\_\_ depression \_\_\_\_ \_\_\_\_ \_\_\_\_\_ learning problem

\_\_\_\_ \_\_\_\_ \_\_\_\_\_ diarrhea \_\_\_\_ \_\_\_\_ \_\_\_\_\_ moodiness

\_\_\_\_ \_\_\_\_ \_\_\_\_\_ dry skin \_\_\_\_ \_\_\_\_ \_\_\_\_\_ stuffy nose

\_\_\_\_ \_\_\_\_ \_\_\_\_\_ earache(s) \_\_\_\_ \_\_\_\_ \_\_\_\_\_ thrush

\_\_\_\_ \_\_\_\_ \_\_\_\_\_ eczema/rash \_\_\_\_ \_\_\_\_ \_\_\_\_\_ vomiting spells

others: please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Review of Symptoms**

Height:\_\_\_\_\_\_\_\_\_\_\_\_\_Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any major weight changes in the past year? □ Yes □ No

If yes, how much:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the child have any medical alerts?\_\_\_\_\_\_\_\_\_\_\_\_

How many hours of **sleep** does your child average per night?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does he/she wake rested? □ Yes □ No

Does he/she wake at night? □ Yes □ No If yes, why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What kind of exercise or activities does your child enjoy? ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does Dr. Bean have permission to communicate with you via email? **Y or N**

Does Dr. Bean have permission to send you her monthly newsletter containing health articles and upcoming events**? Y or N**

Does Dr. Bean have permission to send you SMS reminders? **Y or N**

Signature of Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_