Dr. George Tardik, ND

Dr Sarah Vosburg ND

Living Well Health Centre

Naturopathic Paediatric Intake (0-12)

Name _____ Date _____

Date of birth _____ Sex M F

Address

_____

_____

_____

Phone _____ h

_____ w

_____ other

May we leave messages relating to your visits?
Y N
Which one?

Emergency contact: Name _____ Phone _____

Referred by _____

Other health care providers

1. _____ 2. _____ 3. _____

_____ _____ _____

_____ _____ _____

(_____)_____ (_____)_____ (_____)_____

Health concerns you would like help with

1. _____
2. _____
3. _____
4. _____
5. _____

Medical history

General state of health - briefly describe

Please check the following conditions, which apply, if a choice is given, please circle the appropriate one.

□ Lung Disease

□ Anemia or Sickle cell

□ Arthritis/ Joint Disease

□ Blood Clots/ Phlebitis

□ Cancer (type) _____

□ Diabetes (Type I – Juvenile)

□ Digestive (type) _____

□ Bleeding easily

□ Frequent Sinusitis

□ Gall Bladder Trouble

□ Hay Fever, Allergy, Eczema

□ Hearing Loss

□ Urinary Difficulties (infection, etc.)

□ Heart Murmur

□ Headaches

□ High Blood Pressure

□ High Cholesterol

□ Other

□ Kidney Infection/ Stones

□ Liver Disease, Hepatitis, etc.

□ Mental Trouble/ Depression/ Anxiety

□ Pneumonia

□ Radiation or Chemo Therapy

□ Rheumatic Fever

□ Seizures, Epilepsy

□ Serious Injury or Accident _____

□ Frequent ear infections

□ Skin Disease _____

□ Insomni/problems sleeping

□ Thyroid Disease

□ Tuberculosis

□ ADHD/ADD

□ Vision Problems

□ Other _____

□ Other _____

□ Other _____

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates

_____

_____

_____

_____

Does your child have any allergies (medicines, environmental, etc.)?

_____

_____

Prescription Medications/Supplements – please list on the table below all medications you are taking.

Name of Medication or Product & strength	**How often do you take this medication?**	**How much do you take for each dose?**	**When did you start taking this medication?**	**Why or what medical condition are you taking this medication for?**	**When did you stop taking this medication? And why?**

Additional prescription medications or natural medicines

_____

_____

_____

_____

_____

How many times has your child been treated with antibiotics (or provide an average per year)? _____

Did the mother of the child use any of the following during pregnancy? (circle)

Aspirin Laxatives Antacids Diet pills

Alcohol—how much/day or week _____

Tobacco—form and amount/day _____

Caffeine—form and amount/day _____

Recreational drugs—what and how often _____

Please indicate what immunizations your child has had

☐ DPT (diphtheria, pertussis, tetanus)	☐ Haemophilus influenza B	☐ Hepatitis A
☐ Tetanus booster; when? _____	☐ "Flu"	☐ Hepatitis B
☐ MMR (measles, mumps, rubella)	☐ Polio	☐ Smallpox

Other _____

Please indicate if any caused adverse reactions

_____

Does your child visit their family doctor on a regular basis? Y / N

Diet

Food allergies or intolerances? Please list.

_____

_____

_____

Dietary restrictions (religious, vegetarian, etc.)?

_____

_____

Describe a typical day's diet (if the child is breastfeeding just indicate this in any of the space provided)

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (and total quantity) _____

Family history

Indicate if a close relative (parent, grandparent, sibling) has had any of the following:

	Who?		Who?
Allergies		Kidney disease	
Asthma		Liver Disease	
Cardiovascular disease		Lung Disease	
Cyst		Other mental illness	
Cancer		Seizures	
Diabetes		Stroke	
Digestive		Thyroid Disease	
Depression		Tuberculosis	
Drug abuse/alcoholism		Ulcers	
Easy Bleeding		Other	
High Blood Pressure		Other	
Headaches		Other	

☐ I don't know my family medical history

Environment

Does your child have any hobbies?

_____

_____

Exposure to significant tobacco smoke (work, home, etc.)? Y / N

Frequently exposed to animals (work, pets, etc.)? Y / N

How is your home heated?

_____ Regularly exposed to toxins or other hazards (home, hobbies, etc.)? Please describe.

_____

_____

_____

_____

How would you describe the emotional climate of your home?

_____

_____

How stressful is school for them, or other aspects of their life? How well do they handle these stresses?

_____

_____

_____

Is there anything that you feel is important that has not been covered?

_____
_____
_____
_____

Do they exercise regularly? (leave blank if this does not apply) Y / N what do they do for exercise, how much, how often?

_____
_____
_____
_____
_____
_____
_____
_____

Thank you