Rebalance LONDON | Naturopathic & Wellness Clinic

PEDIATRIC INTAKE FORM

PATIENT INFORMATION

First & Last Name:_____

Date of Birth: _____ Age: _____ Gender: M or F

Height: _____ Weight: _____

Names of Parents/ Guardians: _____

Address: _____

Town/City: _____Province: _____ Postal Code:_____

Home Phone Number: _____

Work Phone number: _____

Email: _____

Emergency Contact:

_____

Relationship: _____

Phone Number: _____

Patient's Primary Care Physician/Pediatrician:

_____

Phone Number: _____ Address: _____

Person Completing this form: _____

Relationship: _____

How did you hear about our clinic (We love details-ie if search engine, what did you put in)?

_____

Where you referred to our office? Y or N If yes, by whom?

_____

205 OXFORD ST E. UNIT 109
LONDON, ON N6A 5G6
PH: 519-601-2002

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 {c} or in the past {p}.

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

VACCINATION HISTORY

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

- ❑ Diptheria date _____
- ❑ Pertussis date _____
- ❑ Tetanus date _____
- ❑ Polio date _____
- ❑ Hemophilus Influenza B date _____
- ❑ Measles date _____
- ❑ Mumps date _____
- ❑ Rubella date _____
- ❑ Hepatitis B date _____
- ❑ Chicken Pox date _____

Did you child experience any adverse reactions to these vaccines? Y or 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:

_____

_____

FAMILY HISTORY

Please indicate whether any family member has/had any of the following:

	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

Based on our website/your own interests was there any forms of therapy that really caught your eye/you are interested in: Ex acupuncture, diet and lifestyle counselling, nutritional supplements, herbs, B12/Vitamin D shots, IV Vitamin Therapy (Please Circle any/all).

_____

_____

Was there any testing that you were interested in having done for your child (food sensitivity testing, nutritional testing, hormone testing)_____

Are there any obstacles to healing/treatment options. Examples: very busy home life, lack of routine, financial, picky eater, not much time dedicated to cooking/making lifestyle changes

_____

_____