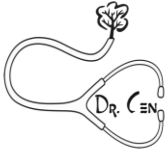

Dr. Han Ping Helen Cen, ND #5-9977 178 Street NW, Edmonton, AB
www.drcennd.ca 780-757-3355

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. This location accepts cash and credit cards as methods of payment, no debit payment is accepted currently.

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?

____
____
____
____

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

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? ________________

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.