Dr. Glenna Calder ND
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♥Pediatric Intake Form♥

Thank you for taking the time to fill out this form for your child. As an ND, I integrate the unique physical and emotional aspects of your child into his/her treatment program, and the information obtained in this form is of great importance in understanding your child's overall health and well-being. Any questions you may have will be addressed on the first visit.

♥Child's full name_____ Age_____ Date of Birth_____ Sex? (M/F)_____
♥ Address_____City_____Postal Code_____
Phone_____ Email address_____
♥Full name of Mother/Guardian _____ Phone (H)_____
Occupation & Location_____ Phone(W)_____ Fax_____
♥Full name of Father/Guardian _____ Phone (H)_____
Occupation & Location_____ Phone(W)_____ Fax_____
♥Marital status of parents_____
♥Please indicate any special living arrangements your child may have_____
♥Emergency Contact/Number_____ Emergency Contact/Number_____
♥Names of siblings & ages _____
♥Family Physician_____ Other Health Care Practitioners_____
♥How did you hear about this clinic?_____

Health Concerns (in order of importance)?

1.	**2.**	**3.**
4.	**5.**	**6.**

Medical History

Date of last physical exam_____ Height_____ Weight_____ Blood Type_____
Hours of sleep per night?_____ Bedtime?_____ Sleeping problems?_____
Current Medications and Dosages (including over the counter)_____
_____
Past Medications_____
How many times has your child been treated with antibiotics?_____
Current Vitamins, Minerals, Supplements or Herbal products and Dosages_____
_____
Does your child have any allergies?_____ To what?_____
Does your child experience frequent colds and/or flues (now or in the past)?_____
Has your child had X-rays?_____ If so, when and why?_____
Has your child had labwork or other medical testing in the last year? _____ List and explain _____
_____ _____

Please circle which of the following diseases your child has had: *Measles German Measles Chicken Pox Mumps Whooping Cough Strep throat Impetigo Scarlet Fever Mononucleosis Other*_____

Please circle which vaccinations your child has had: *Tetanus Pertussis Diptheria Polio Measles Mumps Rubella Varicella Hepatitis B Influenza Other*_____
Please note any reactions to these vaccinations (fever, etc)_____

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Medical History Continued

Event	Age	Event	Age
1.		2.	
3.		4.	
5.		6.	

Age of mother at conception_____ Mother's health at the time (please circle) *Excellent Good Fair Poor*
Medications taken at conception and during the pregnancy (prescription and over-the-counter)_____
_____
Vitamins/Supplements/Herbs taken at conception and during pregnancy_____
_____
Was this a particularly emotional time for the mother? (Explain)_____

Please circle which of the following the mother experienced during the pregnancy: *Nausea Vomiting Bleeding Diabetes Thyroid Problems High Blood Pressure Pre-Eclampsia Eclampsia Physical Trauma Emotional Trauma* Other_____

Were cigarettes, alcohol or recreational drugs used?_____ Which/How often?_____

•**Biological Father** (where possible)
Age of father at conception_____ Father's health at the time (please circle) *Excellent Good Fair Poor*
Medications/Supplements taken by the father at the time of conception_____
Was this a particularly emotional time for the father? (Explain) _____

Labour History

Place of Birth_____ Vaginal Delivery or C-Section?_____ Length of Labour_____
Was the pregnancy (please circle): *Full term Premature Past term* Were there any complications?_____
Were any medications/interventions used? (ie pitosin, forceps, etc)_____

Neonatal History

Weight_____ Length_____ APGAR scores_____ Any concerns at birth?_____
Was this child breast-fed?_____ Until what age?_____ If no, what formula was given?_____
Were there any feeding problems?_____ Were solid foods given before 6 months of age?_____
Please indicate the approximate age at which the following were introduced: *Formula & Type* _____
*Fruit*_____ *Vegetables*_____ *Soy*_____ *Milk*_____ *Eggs*_____ *Wheat*_____ *Meat*_____
Please explain any adverse reactions_____

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Nutritional Habits

Please describe a typical day's diet for your child:
Breakfast_____
Lunch_____
Dinner_____
Snacks_____
Beverages_____
Please list your child's favorite foods_____

Development and Social Interaction

Do you feel that your child was delayed in reaching any of the following milestones (please circle)? *Holding head* *Smiling* *Rolling over* *Sleeping through the night* *Sitting* *Crawling* *Speaking* *Walking* *Toilet Training* *Reading* *Writing*
Do you feel that this child is growing at an acceptable rate physically, mentally, and emotionally? (Explain)_____
_____
Has your child ever been evaluated for (please circle*)* *Hearing* *Speech* *Language* *Other* Explain_____
How would you describe your child's academic achievement?_____
How would you describe your child's social interaction with peers?_____
How would you describe your child's temperament?_____
Does your child throw tantrums or have any destructive or odd interests which concern you? (Explain)_____
_____
Does your child suffer from any of the following (please circle) *Nightmares* *Daydreaming* *Nervousness* *Moodiness* *Unusual Fears* *Easy crying* *Separation anxiety* *Sleepwalking* *Hyperactivity* *Memory loss* *Fainting* *Seizures*
Explain_____
Has this child ever been a victim of mental, emotional, physical or sexual abuse?_____
Explain_____

Environment

Are there any pets in the child's home?_____ Does he/she have seasonal allergies? _____
Is he/she affected by any of the following? (Please circle) *Perfumes* *Molds* *Trees* *Grasses* *Weeds* *Molds* *Dust* *Animals*
Does anyone smoke inside the child's home?_____
Does your child live/sleep in a basement?_____ Near a farm?_____ On a farm?_____
Approximately what year was your child's home/ dwelling built?_____ How is it heated?_____
Do you use chemicals on your lawn/garden?_____ What is your source of drinking water?_____
Is your child exposed to any chemicals/hazardous materials on a daily basis?_____
Can you think of anything in your child's home/school environment which might adversely affect his/her health (Explain)_____
_____

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Family Medical History: Please check the appropriate box if any family members have had the following conditions

	Mother	Father	Sister/Brother	Grandparents	Other Relative
Autoimmune Disease (Lupus, etc)					
Alcoholism					
Allergies/Asthma					
Anemia					
Arthritis					
Cancer					
Depression/Mood swings					
Diabetes					
Eczema/Psoriasis					
Epilepsy					
Heart Disease					
Hyperactivity					
Kidney Disease					
Learning Disability					
Psychological Disorder					
Other					

Is there anything else that you feel I should know about your child? Please comment.