LIVING WELL
INTEGRATIVE HEALTH CENTRE

Dr. Sarah Vosburgh, B.Sc., ND

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. _____

_____ _____ _____

_____ _____ _____

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

What are your health concerns, in order of importance to you?

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

Medical history

Please describe your general state of health briefly?

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

□ Alcoholism or Substance abuse

□ Anemia or Sickle cell

□ Arthritis/ Joint Disease

□ Blood Clots/ Phlebitis

□ Cancer (type) _____

□ Diabetes

□ Digestive (type) _____

□ Bleeding easily

□ Frequent Sinusitis

□ Gall Bladder Trouble

□ Hay Fever, Allergy, Eczema

□ Hearing Loss

□ Other

□ Heart Murmur

□ Headaches

□ High Blood Pressure

□ High Cholesterol

□ Other

□ Kidney Infection/ Stones

□ Liver Disease, Hepatitis, etc.

□ Lung Disease

□ Mental Trouble/ Depression/ Anxiety

□ Pneumonia

□ Radiation or Chemo Therapy

□ Rheumatic Fever

□ Seizures, Epilepsy

□ Serious Injury or Accident _____

□ Sexually Transmitted Disease _____

□ Skin Disease _____

□ Other

□ Thyroid Disease

□ Tuberculosis

□ Urinary Difficulties (infection, etc.)

□ 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?**

Please list past prescription medications.

_____
_____
_____
_____
_____

How many times have you been treated with antibiotics? _____

Do you use any of the following? (circle)

Aspirin Laxatives Antacids Diet pills Birth control 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 you have 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

_____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)? Y / N

Young Women Only (please leave blank if this does not apply)

Reproductive History

Age at 1st menstrual period _____ First day of most recent menstrual period _____

Usual Flow: Heavy _____ Moderate _____ Light _____ Length of period in days _____

Number of days between periods _____ Clots in menstrual flow _____ Colour of flow _____

Do you have (please circle): Painful Periods, Missed Periods, Spotting Between Periods, Vaginal Bleeding, Unusual Discharge/ Infection, Recurring Vaginal Infections

Date of last Pap _____ History of abnormal Pap? _____

Number of: Pregnancies _____ Live Births _____ Abortions _____ Miscarriages _____

Have you experienced complications during pregnancy/delivery/other problems?

Contraceptive History

What type of contraception are you taking? _____

Problems with the current method? _____

Diet

Do you have any food allergies or intolerances? Please list.

_____

_____

_____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____

_____

Describe a typical day's diet

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (and total quantity) _____

Family history

Indicate if a close relative (parent, child, 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

Hobbies _____

_____

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

How is your home heated? _____

Are you regularly exposed to toxins or other hazards (work, 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? Y / N what do they do for exercise, how much, how often?

_____

_____

_____

_____

_____

_____

_____

_____

Thank you