Inside Total Body Wellness
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Jeremy Toman ND
Viable Healthcare with Natural Options.

Optimize Healthing Centre
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Pediatric Intake Form (child under 13)- Naturopathic

The following information is confidential and will only be released with your authorization.

Patient Name: _____ Date: _____ Sex (circle): M F

Age: _____ Grade of School: _____ Date of Birth: _____

Mother's Name/Occupation: _____

Father's Name/Occupation: _____

Parents are (circle): Married Separated Divorced Common Law Other

Address: _____ City: _____ Province: _____

Postal Code: _____ E-mail Address: _____

Telephone Number: Home: _____ Work: _____ Cell: _____

May we leave messages relating to your child's visits? Y / N Which Phone Number? _____

How did you first hear of Dr. Jeremy Toman ND? _____ Referred By: _____

Family Pediatrician: _____ Ph (_____)_____

Other Health Providers Your Child is Seeing:

Name: _____ Name:_____ Name:_____

Specialty _____ Specialty:_____ Specialty_____

Ph (_____)_____ Ph (_____)_____ Ph (_____)_____

Date of Last Visit:_____ Date of Last Visit:_____ Date of Last Visit:_____

HEALTH GOALS

Please list your child's health concerns in order of significance

Health Concern	Onset Date	Previous Diagnosis? If so, what?	Diagnosis made by?
1			
2			
3			
4			
5			

Short-term health goals? _____

Long-term goals? _____

MEDICAL HISTORY

Does your child have any known allergies (medicine, environmental, food, animals)? Frequency

_____

_____

_____

_____

Please list all CURRENT medications/natural health products (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

Current Medications/Supplements	Brand	Strength (mg, mcg)	Frequency	Treatment for	Start Date

Has your child ever had blood work done? If so, when? _____

Please list PAST prescription medications/natural health products.

Past Medications/Supplements	Treatment For	Start Date	End Date

Has your child ever experienced any serious conditions, illnesses, injuries, surgeries, hospitalizations?

Serious Conditions / Illnesses/Injuries / Surgery / Hospitalizations	Date	Degree of Impact (low, moderate, high)	Comment

Yes indicates the child gets the problem regularly; No indicates the child never had the problem; Past indicates the child had the problem in the past but not recently. Please circle the correct one for your child.

Ear Infections? Yes No Past If has had, how many total? _____

Colds? Yes No Past If has had, how many total? _____

Strep throat? Yes No Past If has had, how many total? _____

How many times has the child taken antibiotics:_____

Hearing tests Normal: Yes No Not Tested

Vision Tests Normal: Yes No Not Tested

Any speech impediments: Yes No Past

Learning impediments: Yes No Don't know

Please check which immunizations/vaccinations you have had and the approximate date of administration:

	Date		Date		Date
☐ **All Scheduled**		☐ Hepatitis A		☐ Flu shot	
☐ Tetanus		☐ Hepatitis B		☐ HPV (Gardasil)	
☐ Polio		☐ Small Pox		☐ Influenza A (H1N1)	
☐ MMR		☐ Meningitis		☐ DPTP	
☐ HiB		☐ Chicken Pox		☐ Other	

Did any immunizations cause complications? _____

Please circle:

Jaundice as baby:	Yes No	Colic:	Yes No
Cradle cap:	Yes No	Anemia:	Yes No
Eczema or psoriasis:	Yes No	Asthma:	Yes No
Diarrhea:	Yes No	Warts:	Yes No
Constipation:	Yes No	Nightmares:	Yes No
Finicky eating:	Yes No	Bed-wetting:	Yes No
Poor teeth:	Yes No	Tantrums:	Yes No
Chronic sniffles:	Yes No	Disobedient:	Yes No
Bad foot odor:	Yes No	Fears/Phobia:	Yes No
Very sweaty baby/child:	Yes No	Diaper Rash:	Yes No
Hyperactivity:	Yes No	Early Puberty:	Yes No
Growing pains:	Yes No	Stomach aches:	Yes No

PREGNANCY & EARLY LIFE HISTORY

Age at conception:_____ Any pregnancy complications? _____

During Pregnancy

Smoking:	Yes No	Diabetes:	Yes No
Coffee:	Yes No	Nausea/Vomiting:	Yes No
Recreational drugs:	Yes No	Emotional Stress:	Yes No
Preeclampsia:	Yes No	Length of Labor:	_____

Mode of Delivery: _____ Traumatic birth: Yes No

If the birth was difficult, please explain:

_____

Health of baby at birth:_____

Child breastfed: Yes No For how long?: _____

Was your child given formula?: _____ What formula was used?: _____

When was solid food introduced?: _____ When did child walk?: _____

Talk?:_____ When did child first develop teeth?: _____

PERSONAL/PSYCHOSOCIAL HISTORY

Describe your child's personality? _____

_____

Any particular household stressors your child has witnessed or gone through?:

1. _____

2. _____

3. _____

How would you describe the emotional climate of your home?

_____

_____

FAMILY HISTORY

Please indicate any diseases/conditions that have occurred in your family . If the person is a grandparent or extended family member, specify maternal (M) or paternal (P) side.

Condition	Who? (Sibling(s), Mother, Father, Grandparent, Uncle/Aunt)	M	P	Age of Onset
Alcoholism/Addiction				
Allergies				
Asthma				
Cancer				
Diabetes				
Eczema/Psoriasis				
Depression/Other mental illness				
Heart Disease				
Nervousness/Anxiety				
Thyroid conditions				
Digestive Illness				
Osteoporosis				
Weight Concerns				
Anything Else?				

DIET

Typical Daily Sample Menu (include all beverages)

Meal	Time of Meal	Symptoms After Eating
Breakfast:		
Lunch:		
Dinner:		

Favourite Food? _____ Least Favourite Food? _____

ENVIRONMENT/TOXIN EXPOSURE

Is your child exposed to second-hand smoke on a regular basis (circle)? Yes No

Has the child ever lived in a house with lead paint? Yes No

Do you spray pesticides or herbicides around the house or use other toxic chemicals? Yes No

If Yes, What? _____

SLEEP

# of Hours/Night _____ Bed Time? _____ How long does it take your child to fall asleep? _____

Wake Time? _____ # of nightly wakings? _____ What for? _____

Any nightmares or night terrors? _____

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

_____

_____

_____

_____

Thank you for taking the time to fill out this form. It helps me to understand your child as an individual so that we can work together to restore and maintain their health.

Connect with Dr. Jeremy Toman ND @:

Website: www.JeremyTomanND.com

Facebook: /JeremyTomannND

Google+: /+JeremyTomanNDWalkerton

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Please feel free to leave an online review.