Dr. Jese Anne Wiens ND
Naturopathic Doctor

Rise Wellness Centre
101-2504 Skaha Lake Road
Penticton 778-476-2550

Pediatric Intake Form (Birth - 12 years)

Patient's name: _____ Date of first visit: _____
Age: _____ Date of Birth: _____/_____/_____ Gender: M / F
Mother's name:_____ Father's name: _____
Address: _____City: _____ Prov: _____ Postal code: _
Phone # (home): _____ Parents # (work/cell): _____
Parents e-mail address: _____
How did you hear about Dr. Wiens? _____
Name of Dr.'s Office/Hospital/Clinic where your child's health records are kept: _____
_____
Child's health issues, in order of importance: _____
_____

Current Medications & Supplements

Medication/supplement	Since	Dose & Reason

Medical History of infections

_____ Chicken pox
_____ Pneumonia
_____ Pertussis
_____ Other viral illness (measles, mumps, rubella)
_____Other bacterial illness (scarlet fever, rhumatic fever)
_____ Tonsillitis, approx. no. _____
_____ Ear infections, no. _____
_____ other (please list) _____

Injuries/Surgeries/Hospitalizations (please list): _____
_____

Immunizations

Please indicate which have been received and the age.

_____ all scheduled vaccines up to date
_____ DTPa/polio/Hib/Hep B
_____ Hepatitis B
_____Meningitis
_____Pneumococcus
_____ MMR
_____ Chicken pox
_____ Influenza
_____ HPV
_____rotavirus

Any adverse reactions? Y N What ? _____

PLEASE COMPLETE BOTH SIDES

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Prenatal History

Number of previous pregnancies by mother_____Mother's age at child's birth? _____

Mother's health during pregnancy:

_____ Physical or emotional trauma _____ Bleeding _____ Nausea
_____ Cigarettes, alcohol, drug consumption _____ Medications
_____ Hypertension or pre-eclampsia _____ Thyroid problems _____ Diabetes

Any other pregnancy complications or illnesses?

Birth History

Term: Full _____ Premature _____ Late _____ Weight at birth_____

Length of labor _____ Complications? _____

Did your child have any of the following problems shortly after birth?

_____ Birth defects _____ Birth injuries _____ Breathing problems
_____ Cerebral palsy _____ Seizures _____ Jaundice
_____ Colic _____ Fever _____ Rashes

Other (explain) _____

Growth & Development (applicable for ages 0 – 3)

Feeding: Breast fed? _____how long? _____ Formula? _____

Age began solids _____ Which foods? _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

Symptoms (mark **Y** if current, **P** <u>significant</u> past symptom)

_____ Hives _____ Headaches _____ Fatigue
_____ Allergies _____ Vomiting spells _____ Anemia
_____ Eczema or rash _____ Stomach aches _____ High fevers
_____ Wheezing _____ Motion sickness _____ Sore throats
_____ Easy bruising _____ Gas _____ Frequent colds
_____ Cries easily _____ No appetite _____ Sore ears
_____hyperactive _____ Diarrhea _____ Cough
_____ Anxiety _____ Constipation _____Asthma
_____ Sleep problems _____ Frequent urination
_____ Unusual fears _____ Joint pains

Other major symptoms currently:_____

Typical Daily Diet:

Breakfast:_____
Lunch: _____
Dinner: _____
Snacks:_____
To Drink: _____
Food intolerances (if any) _____

Welcome! We're honoured to be of service to you and your child.