ZENTAI
wellness centre
"Helping You With Wellness, Not Just Illness"

Pediatric and Teenager Patient Intake Form

Personal Information

Name____ Date ___________________

Date of birth ______________________ Age ______ Sex: □ Male □ Female

Address ____ City ______________________

Province _________________________ Postal Code __________________

Phone: Home ____________________ Work ______________________ Other ____________

Email ___________________________ May we leave messages relating to your visits? □ Yes □ No

Would you like to receive our email newsletter? □ Yes □ No

Who is filling out this form (name and relation)?____

Emergency contact:

Name ____________________Relation _____________________ Phone ________________

How did you hear about our clinic? ____

Other health care providers (family physician, specialists, complementary and alternative therapy):

1.______________________ 2.______________________ 3.______________________

Ph:____________________ Ph:_____________________ Ph:_____________________

What are the main health concerns that you would like addressed:

1. ____
2. ____
3. ____
4. ____
5. ____

Medical history

How would you describe your general state of health? □ Excellent □ Good □ Fair □ Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates.

____

____

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Do you have any allergies (medicines, environmental, etc.)?

____

____

Please list all current medications, including dosages, duration of use and why you are taking them.

Medication	Dose	Duration	Condition Treating

Please list all natural health products you are taking (vitamins, supplements, herbs, homeopathics).

Natural Health Product	Dose	Duration	Condition Treating

Please list past prescription medications.

____

____

How frequently are you treated with antibiotics? ___________________________

Dr. Aileen Lim-Trotter, B.Sc., N.D.
Naturopathic Doctor

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Do you regularly use any of the following?

□ Aspirin □ Laxatives □ Antacids □ Diet pills □ Birth control pills □ Implants □ Injections

Alcohol—how much/ day or week ______________________________

Tobacco—form and amount/day ______________________________

Caffeine—form and amount/day ______________________________

Recreational drugs—what and how often ____

Please indicate which 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: ____

Please indicate with a check mark if you have experienced any of the following conditions:

	Currently	Past		Currently	Past
Acne			Epilepsy/Seizure		
Allergies			Fatigue		
Anemia			Frequent Infections		
Asthma			Headache		
Bed Wetting			Heart Murmur		
Birth Defects			High Fever		
Colic			Hyperactivity		
Constipation			Insomnia		
Cough/Wheeze			Jaundice		
Cradle Cap			Learning Disorder		
Depression			Moodiness		
Diarrhea			Stuffy Nose		
Dizzy Spells			Thrush		
Earaches/Ear Infection			Vomiting		
Eczema			Other		

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)? □ Yes □ No

When were your most recent tests performed? ____

Prenatal and Infant History

Mother's health during pregnancy:

Age of Mother and Father	
Trauma/Injury	
Alcohol Consumption/Drugs/Smoking	
Bleeding	
Stress	
Toxemia	

Nausea	
High Blood Pressure	
Illness	
X-rays	
Diabetes	
Medications	

Pregnancy Term:

Premature	
Full birth weight	
Easy/Difficult Pregnancy	
C-Section	
Breech	

Feeding of Infant

Breast Fed? For how long?	
Milk? What type and how long?	
Formula fed? What type and how long?	
Age solid food introduced	
What foods were introduced first?	

Diet

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

____

____

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

____

____

Family history

Indicate if a close relative (parent, child, sibling) has had any of the following:

	Who?		Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug abuse/alcoholism	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes			

☐ I don't know my family medical history

Environment

What grade are you in? ____

Hobbies ____

Do you exercise regularly? □ Yes □ No

What do you do for exercise, for what duration and how often?

____

____

Are you exposed to significant tobacco smoke (at work, home, etc.)? □ Yes □ No

Are you frequently exposed to animals (work, pets, etc.)? □ Yes □ No

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 would you rate your stress levels?

□ Overwhelming □ High □ Moderate □ Low □ Minimal

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

____

____

____

Are there any other services you would like to learn more about?

□ Massage Therapy/Shiatsu

□ Psychotherapy

□ Chiropractic

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