Dr. Romi Raina ND
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NATUROPATHIC PEDIATRIC/CHILD INTAKE FORM

Name:		Date of 1st Visit:		
Date of Birth: dd /mm /yyyy	Age:	Gender:	Height:	Weight:
Address:				
City:		Prov:	Postal Code:	
Phone (home):		Phone (work):		
Phone (cell):		Email:		
Person completing this form:				
Name of Guardian:		Relationship:		
Name of Guardian:		Relationship:		
With whom does this child live?				
Was this child adopted?	If yes, at what age?			

EMERGENCY CONTACT

Name:	Relationship:
Phone (home):	(work/cell):

How did you hear about Dr. Romi Raina ND? _____

Health Concerns

What are your main health concerns? (in order of importance to you)	How long have you had this concern?
1.	
2.	
3.	
4.	
5.	

Other Health Care Providers

1.	2.
Phone:	Phone:
Fax:	Fax:

Please list all prescriptions, over the counter medications, supplements, products the child is taking

Medication/Natural Health Product	Reason Taking	How long

How many times has the child been treated with antibiotics? _____

Year Illness, Surgery, Injury, Major Medical Diagnosis

_____ _____

_____ _____

_____ _____

Please list all allergies: (food, environmental, medications, etc)

_____

_____

Please indicate if your child experienced any reaction or illnesses following a vaccination. Please indicate what the reaction was and to which vaccination(s)

_____

_____

Please describe any problems with conception or infertility treatment received for this child:

_____

_____

Were there any birth complications? (ie breech) _____

Was the child breastfed? _____ For how long? _____

Schooling: ☐ school ☐ daycare ☐ homecare ☐ other What grade level? _____

General school/daycare behaviour/performance:_____

_____

Marital status of the child's parents: ☐ Married ☐ Divorced ☐ Separated

How is the child's behaviour at home? _____

Does your child have any habits? _____ Any fears? _____

Has the child been diagnosed with any learning disabilities? _____

Does your child make friends easily? _____

Child's interests and favourite activities: _____

How many hours/week does your child: Play on the computer or video games? _____ Exercise? _____

Watch television? _____ Read? (not for school) _____

Please describe your child's eating behaviours (eg. Good appetite, picky eater, etc.)

_____

Does your child have any strong food cravings or aversions? _____

Thank you for taking the time to fill in this form.