

Happy N' Healthy Naturopathy
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Pediatric Intake Form
newborn-5 year old

Who are you?

Name: _____

Gender: M F

Age: _____

Date of Birth: _____

Parent's

Names: _____

Address: _____

Who does the child live

with: _____

Phone Number:(____) _____

Emergency Contact: _____ Phone

Number: _____

Does the child have a medic

alert? _____

Or life threatening

allergies? _____

What's going on?

What is the main health
concern? _____

When did this
begin? _____

How long has this gone on
for? _____

What other treatments have been attempted? _____

What was the result with these treatments? _____

What have you had? Check all applicable

Chicken pox	<input type="checkbox"/>	Measles	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	Rubella	<input type="checkbox"/>
Surgery	<input type="checkbox"/>	Allergies	<input type="checkbox"/>

Vaccinations: Check all applicable

D-PTP (Diphtheria, Pertussis, Tetanus, Polio)	<input type="checkbox"/>	Hib (H. influenza, often given with D-PTP)	<input type="checkbox"/>
MMR (Measles, Mumps, Rubella)	<input type="checkbox"/>	Td + P (Tetanus, Diphtheria, Polio)	<input type="checkbox"/>
OPV	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>
Flu shot	<input type="checkbox"/>		<input type="checkbox"/>

Have you ever been to the emergency room? _____

What was it for? _____

What are you taking?

Please list any medications you have taken in the past and the ones you are taking presently. _____

Please list any supplements; vitamins, minerals, herbal medication, homeopathics, that you are currently taking.

How was your birth?

During the pregnancy were you exposed to any of the following: Y or N

Alcohol		Cigarette smoke	
Recreational drugs		Prescription medications	
Over the Counter drugs		Herbal preparations	
Ultrasound		Amniocentesis	
Illness		Large amount of stress	

Were there any complications during the pregnancy? Y or N

Nausea		Hypertension	
Vomiting		Preeclampsia/eclampsia	
Bleeding		Placenta previa	
Gestational diabetes		Maternal rubella	
Maternal chicken pox		Maternal cytomegalovirus	
Maternal toxoplasmosis		Other	

At Birth:

Weight: _____

Length: _____

Were you term? _____ pre-term? _____ post-term? _____
premature? _____

Where did the birth take place? Home Hospital

What type of delivery occurred? Vaginal Cesarean Section

Were there any complications with the birth? Y or N

Difficult delivery		Breech delivery	
Long 2 nd stage of labor		Shoulder dislocation	
Forceps or suction used		Other	

What were the APGAR scores? _____

Were any interventions administered at birth? Vitamin K Eye drops

What were your mother's feelings about the birth? _____

As a Newborn:

Did you have any of the following conditions? Y or N

Jaundice		Colic	
Hip displacement		Meningitis	
Scoliosis			

What do you like to eat?

As a baby were you breastfed? Yes No For how long? _____

Were you fed formula? Yes No

What kind of formula was used? _____

Were there any reactions to the formulas? _____

How old were you when were you introduced to food? _____

What did you eat first? _____

Were there any reactions to any foods? _____

What do you eat now? _____

What are your favorite foods? _____

What foods do you like the least? _____

Do you exclude any foods for religious or ethnic reasons? _____

Where do you live?

What kind of a building do you live in (house, apartment, etc.)? _____

How old is the building? _____

Has it been renovated recently? _____

Does your home have carpet? _____

Has there ever been a problem with mildew in the home? _____

What is your family like?

Has anyone in your family had any of the following diseases? Y or N

Cancer		Diabetes		Heart Disease	
Stroke		Hypothyroidism		Arrhythmia	
Rheumatoid Arthritis		Hyperthyroidism		High blood pressure	
Lupus		Sickle-cell anemia		Crohn's Disease	
An Autoimmune disease		Irritable Bowel Syndrome		Ulcerative Colitis	

What do you like to do?

Do you go to school? Which one? _____

Do you go to daycare? _____

Do you have a nanny? _____

How do you like playing with other kids? _____

Do you have a pet? _____

Do you watch TV? Yes No How often? _____

Do you play video games? Yes No How often? _____

Do you play on the internet? Yes No How often? _____

Do you have family time? Yes No How often? _____

Do you get exercise? Yes No

What do you like to do for exercise? _____

What else do you like to do? _____

How is your sleep?

What position do you like to sleep in? _____

How long do you sleep at night? _____

How long does it take you to fall asleep? _____

Do you wake up during the night? _____

Do you have nightmares? _____

How do you feel when you wake up? _____

Are you rested? _____

Do you take naps? _____

How long are your naps? _____

What is your energy like during the day? _____

From Head to Toe: Please check all that apply.

Cradle cap (seborrheic dermatitis)		ADHD/ ADD	
Eczema		Urinary incontinence	
Diaper rash		Bedwetting	
Yeast infection		Fecal incontinence	
Impetigo		Seizures	
Conjunctivitis		Paralysis	
Autism /ASD		Cerebral Palsy	
Sinusitis		Spina bifida	
Ear infections		Cystic Fibrosis	
Chronic Colds		Chronic Diarrhea	
Croup		Appendicitis	
Bronchitis		Constipation	
Asthma		Chronic Abdominal pain	
Pneumonia		Short stature	
Cardiovascular problems		Other	

Informed Consent

I acknowledge and understand that I have been informed and understand that:

1. Any education, advice or health plans provided to me as a client of Happy N' Healthy Naturopathy are **not** to replace medical care that I am receiving from another licensed health care provider or medical doctor.
2. Happy N' Healthy Naturopathy strongly recommends that I am an active patient of a licensed health care provider.
3. I agree to pay for any fees for service, costs of supplements, and remedies at time of service.

First Office Call, New Patient: Fee \$175

This fee covers the first time a patient is seen by Dr. Sinclair, provided the patient *has not been previously* seen at Happy N Healthy. It includes pertinent physical exams, possible lab test to be ordered (fee for labs is separate) and is approximately one and one half hours in length.

First Office Call, *Established* Patient: fee \$120

This fee covers the first time a patient is seen by Dr. Sinclair, provided the patient is *already an established* patient at Happy N Healthy and has been referred by one of the Happy N Healthy Doctors or Nurse Practitioners. It includes pertinent physical exams, possible lab tests to be ordered (fee for labs is separate) and is approximately one and one half hours in length.

Return Office Call: fee \$80

This fee covers successive appointments with Dr. Sinclair. It is approximately one hour in length.

4. I have read the above information and consent to pay for services rendered at the time of service. I acknowledge that I may request the fees for various procedures and medications before they occur or are prescribed, and include that information in the decision regarding my healthcare. I consent to treatment as agreed upon between Dr. Sinclair and myself. Any therapy will proceed only with our mutual consent. I agree to discuss any concerns in my care with Dr. Sinclair.

Signature _____ **date:** _____
(Patient or Parent / Legal Guardian)

Print Name of patient _____