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**Pediatric Intake Form**

**General Information**

Child's name: \_\_\_\_\_ Child's Age: \_\_\_\_\_  
Date of first visit: \_\_\_\_\_ MSP #: \_\_\_\_\_  
Date of birth: : \_\_\_\_\_ Child's grade level: \_\_\_\_\_ Sex: M F  
Who is filling out this form? (name and relationship): \_\_\_\_\_  
How did you learn about Dr. Wickland?: \_\_\_\_\_  
Who does the child live with? \_\_\_\_\_

**Guardian Contact Information :**

Name and relation to child: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone number: (home) \_\_\_\_\_ (alternate) \_\_\_\_\_

Name and relation to child: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone number: (home) \_\_\_\_\_ (alternate) \_\_\_\_\_

Please list child's current health care providers with their designation (pediatrician, family physician etc.) and contact information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have any known contagious diseases at this time?  
No Yes: \_\_\_\_\_

Do your child have any known life-threatening allergies?  
No Yes: \_\_\_\_\_

*Pediatric Health Overview - Comprehensive health care requires a complete picture of health. Please take the time to complete this questionnaire carefully. If you are unsure about a question, mark it and we can discuss it during the visit.*

**PRIMARY HEALTH CONCERNS**

In your opinion, what are your child's most important health concerns?

- 1. \_\_\_\_\_ 4. \_\_\_\_\_
- 2. \_\_\_\_\_ 5. \_\_\_\_\_
- 3. \_\_\_\_\_ 6. \_\_\_\_\_

Can you identify any events (life trauma, surgery, drug reactions) as having caused or aggravated your child's health concerns?

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**MEDICAL HISTORY**

How would you describe your child's general state of health (excellent, good, fair or poor)?

Please indicate any surgeries, hospitalizations, injuries or serious conditions your child has experienced with approximate dates.

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Current medications or supplements:

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Past medications or supplements:

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How many times has your child had antibiotics? \_\_\_\_\_

Does your child have any allergies (medications, environmental)?

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Has your child been to see the dentist? [ ] yes [ ] no

Describe any dental work done: \_\_\_\_\_

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Describe your child's daily oral hygiene practice: \_\_\_\_\_

Has your child had their vision checked? [ ] yes [ ] no

Describe any vision problems: \_\_\_\_\_

Frequency of bowel movements: \_\_\_\_ times per day or \_\_\_\_ times per week

Does your child experience any pain when passing stool? \_\_\_\_\_

Do any of your child's bowel habits concern you? \_\_\_\_\_

Are there any urinary symptoms you are concerned about? \_\_\_\_\_

Has your child ever experienced any of the following conditions? If you are unsure of any of the terminology please put a question mark beside the word.

- |                          |  |                          |  |
|--------------------------|--|--------------------------|--|
| Allergies- seasonal      | <input type="checkbox"/> yes <input type="checkbox"/> no | Measles                  | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Diarrhea                 | <input type="checkbox"/> yes <input type="checkbox"/> no | Cold sores               | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Allergies-environmental  | <input type="checkbox"/> yes <input type="checkbox"/> no | Meningitis               | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Difficulty concentrating | <input type="checkbox"/> yes <input type="checkbox"/> no | Colic                    | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Appendicitis             | <input type="checkbox"/> yes <input type="checkbox"/> no | Mumps                    | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Difficulty sleeping      | <input type="checkbox"/> yes <input type="checkbox"/> no | Conjunctivitis(pink eye) | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Atopic Dermatitis        | <input type="checkbox"/> yes <input type="checkbox"/> no | Pneumonia                | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Ear infection            | <input type="checkbox"/> yes <input type="checkbox"/> no | Constipation             | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Asthma                   | <input type="checkbox"/> yes <input type="checkbox"/> no | Sinusitis                | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Eczema                   | <input type="checkbox"/> yes <input type="checkbox"/> no | Convulsions              | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Bronchitis               | <input type="checkbox"/> yes <input type="checkbox"/> no | Skin rash                | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Frequent colds           | <input type="checkbox"/> yes <input type="checkbox"/> no | Cradle Cap               | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Cancer                   | <input type="checkbox"/> yes <input type="checkbox"/> no | Strep throat             | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Hay fever                | <input type="checkbox"/> yes <input type="checkbox"/> no | Croup                    | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Chicken pox              | <input type="checkbox"/> yes <input type="checkbox"/> no | Thrush                   | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Head lice                | <input type="checkbox"/> yes <input type="checkbox"/> no | Diabetes                 | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Chronic Bedwetting       | <input type="checkbox"/> yes <input type="checkbox"/> no | Tonsilitis               | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Hyperactivity            | <input type="checkbox"/> yes <input type="checkbox"/> no | Diaper rash              | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Chronic nose bleeds      | <input type="checkbox"/> yes <input type="checkbox"/> no | Urinary tract infection  | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Impetigo                 | <input type="checkbox"/> yes <input type="checkbox"/> no | Seizures                 | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Chronic Bruising         | <input type="checkbox"/> yes <input type="checkbox"/> no | Headaches                | <input type="checkbox"/> yes <input type="checkbox"/> no |

**VACCINATION HISTORY**

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Hepatitis B                                     | <input type="checkbox"/> Hemophilus B                    | <input type="checkbox"/> Chicken pox  |
| <input type="checkbox"/> DPT or DT -<br>(Diphtheria, Pertussis, Tetanus) | <input type="checkbox"/> MMR - (Measles, Mumps, Rubella) | <input type="checkbox"/> Flu          |
| <input type="checkbox"/> Polio   | <input type="checkbox"/> Tetanus                         | <input type="checkbox"/> Other: _____ |

Has your child experienced any adverse reactions from a vaccination:  
 No Yes: \_\_\_\_\_

**FAMILY HISTORY**

Have any close relatives had any of the following conditions:

- |                                    |  |   |  |
|------------------------------------|--|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Kidney disease    | <input type="checkbox"/> Depression     | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Seizures  | <input type="checkbox"/> Birth defects     | <input type="checkbox"/> Cancer         | <input type="checkbox"/> Glaucoma            |
| <input type="checkbox"/> Anemia    | <input type="checkbox"/> Psoriasis         | <input type="checkbox"/> Eczema         | <input type="checkbox"/> Juvenile Arthritis  |
| <input type="checkbox"/> Stroke    | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Hay fever           |
| <input type="checkbox"/> Asthma    | <input type="checkbox"/> Bleeding disorder |   |  |

Do either of the parents have any history of chronic illness?

**LIFESTYLE**

What time does your child go to bed? \_\_\_\_\_ Wake up? \_\_\_\_\_

Does your child take naps? \_\_\_\_\_ When? \_\_\_\_\_

Do they have any trouble falling asleep? \_\_\_\_\_

Do they sleep straight through the night? \_\_\_\_\_

Do they wake up looking/acting refreshed? \_\_\_\_\_

Do they have any recurring dreams or nightmares? \_\_\_\_\_

Please write a short description of your child as he/she is currently. Include strengths, weaknesses and major personality traits:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your child currently in school, daycare, at home? \_\_\_\_\_

How would you describe your child's behavior in school/ daycare? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Does this differ greatly from behavior at home? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What makes your child angry? \_\_\_\_\_

Do they have any difficulties expressing anger? \_\_\_\_\_

Do they experience uncontrollable rage? \_\_\_\_\_

What makes your child sad? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Does he/she cry when sad? \_\_\_\_\_

List any major experiences of grief or loss in your child's life \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What fears does your child have? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

How does your child react when afraid? \_\_\_\_\_

What activities does your child enjoy the most? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What is the emotional climate in the child's home? \_\_\_\_\_

Does anyone in the household smoke? \_\_\_\_\_

Does the child exercise regularly? How much and what form of activity? \_\_\_\_\_

How many hours of television does your child watch each day? \_\_\_\_\_

**PRE-NATAL HEALTH AND BIRTH HISTORY**

How old was the mother at the time of the child's birth? \_\_\_\_\_

Number of previous pregnancies the mother carried to term? \_\_\_\_\_

|   | Excellent | Fair | Good | Poor | Unknown |
|---|-----------|------|------|------|---------|
| How was the health of the mother at time of conception?     |           |      |      |      |         |
| How was the health of the father at time of conception?     |           |      |      |      |         |
| How was the health of the mother during the pregnancy?      |           |      |      |      |         |
| How was the emotional state of the mother during pregnancy? |           |      |      |      |         |
| How was the mother's diet during pregnancy?                 |           |      |      |      |         |

Did the mother receive medical care during pregnancy? \_\_\_\_\_

Did the mother use any of the following during her pregnancy?

- alcohol, cigarettes or recreational drugs \_\_\_\_\_
- prescription drugs or over the counter medications (eg. Tylenol) \_\_\_\_\_
- supplements or remedies? \_\_\_\_\_

Were there any interventions used during the pregnancy? (eg. ultrasound or amniocentesis) \_\_\_\_\_

Were there any interventions used or complications during the delivery? (eg. Epidural, forceps, c-section, induction) \_\_\_\_\_

Weight of infant at birth: \_\_\_\_\_

Term length of pregnancy:

[ ] pre-term (37 weeks or less): \_\_\_\_\_ weeks

[ ] full-term (38-42 weeks): \_\_\_\_\_ weeks

[ ] post-term (42 weeks or more): \_\_\_\_\_ weeks

Did the infant experience any of the following conditions during or following the birth?

[ ] injuries during the birth: \_\_\_\_\_

[ ] birth defects: \_\_\_\_\_

[ ] jaundice: \_\_\_\_\_

[ ] infections: \_\_\_\_\_

**DIET HISTORY**

Breast fed? \_\_\_\_\_ How long? \_\_\_\_\_

Approximate feeding schedule? \_\_\_\_\_

Formula? \_\_\_\_\_ How long? \_\_\_\_\_ Combined with breast milk? \_\_\_\_\_

What type of formula was used? (milk, soy, other) \_\_\_\_\_

At what age was solid food first introduced? \_\_\_\_\_

What types of food were introduced and in what order? \_\_\_\_\_

\_\_\_\_\_

Did your child have any reaction to the food being introduced? \_\_\_\_\_

\_\_\_\_\_

Does your child have any known food allergies? \_\_\_\_\_

\_\_\_\_\_

Does your child have any dietary restrictions? (eg. Religious, vegetarian, vegan) \_\_\_\_\_

\_\_\_\_\_

What is a typical day's diet for your child?

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Beverages: \_\_\_\_\_

List any foods that your child seems to crave, regardless of their nutritional value:

Is your child thirsty? [ ] yes [ ] no

Amount of liquid child drinks each day? \_\_\_\_\_

Amount of plain water: \_\_\_\_\_

What temperature of liquid does your child prefer to drink?

What is the approximate weight of your child? \_\_\_\_\_

Has there been any recent weight gain or weight loss? \_\_\_\_\_

Are you satisfied with your child's diet the way that it is now? Why or why not?

Is there anything else you would like to comment on?

*Thank you for taking the time to fill in this information.*

### Declaration and Consent for Naturopathic Care

I would like to take this opportunity to welcome you to our clinic. As a naturopathic doctor (ND) I will conduct a thorough case history, a physical exam and **may** utilize specific blood, urinary or other laboratory reports as part of the treatment work-up. I integrate supportive therapies like nutrition, herbal medicine, homeopathy, acupuncture, physical medicine and lifestyle counseling to assist the body's ability to heal and to improve the quality of life and health.

### Statement of Acknowledgement

Printed name of patient: \_\_\_\_\_

As a patient of Dr. Karina Wickland, I have read the information and understand that the form of medical care is based on **naturopathic** and other supportive principles and practices. I recognize that even the gentlest therapies potentially have their complications. The information I have provided is complete and inclusive of all health concerns including possibility of pregnancy and all current medications, including over the counter drugs. **Slight** health risks of some naturopathic treatments include, but are not limited to:

- temporary aggravation of pre-existing symptoms
- allergic reaction to supplements or herbs
- pain, fainting, bruising or injury from venipuncture or acupuncture
- muscle strains and spasms, disc injuries from spinal manipulations

I also recognize the following:

- I will be given the opportunity to discuss and consent to any treatment plan.
- Any treatment or advice provided to me as a patient of Dr. Wickland is **not mutually exclusive** from any treatment that I may now be receiving or may in the future receive from another licensed healthcare provider. I am at liberty to seek or continue medical care from a medical doctor or other healthcare providers. I understand results are not guaranteed.
- I understand that a record will be kept of my visits. This record will be kept confidential and **will not be released** without my consent. I understand that I may look at my medical records at any time and can request a copy of them.
- I am responsible for **payment at the time services are rendered**. Dispensary items must be paid for in full before leaving the office.
- I am aware that **24 hours notice** must be given for all cancelled appointments or a **cancellation fee** will be applied.
- I understand that Dr. Wickland reserves the right to determine which cases fall outside of her scope of practice, in which case the **appropriate referral will be recommended**.

I consent to receive naturopathic treatment from Dr. Karina Wickland. I understand this consent is voluntary and may be revoked at any time.

Signature of patient or guardian: \_\_\_\_\_

Date: \_\_\_\_\_