Dr. Kathleen Cannon, Naturopathic Physician
Access to Health Chiropractic Center
57 Lafayette Street
Norwich, CT 06360

New Patient Intake Form + Health Questionnaire **(Pediatric)**

Child + Parent Information

Child's First Name:	Middle Name:	Last Name:
Preferred Name:	Gender: Age:	Date of Birth:
Parent(s) or Guardian(s):		
Phone 1: Voicemail consent: Y / N		
Phone 2: Voicemail consent: Y / N		
Email: Email Consent: Y / N *(email is not a secure communication)*		
Street Address:		
City/Town:	State:	Zip:

Parent or Guardian Work Information

Occupation:	Employer:
Work Address:	

Emergency Contact

Name:	Relationship to you:
Phone 1:	Phone 2:

Other Healthcare Providers

Pediatrician:	Phone:

Please list any other doctors.

Name:	Specialty:	Phone:
Name:	Specialty:	Phone:
Name:	Specialty:	Phone:
Name:	Specialty:	Phone:
Name:	Specialty:	Phone:

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Other Information

Have you or your child seen a naturopathic doctor before? Y / N If Yes: child or adult?
If yes, who did you see?
Please describe your experience:
What are you most interested in at our clinic?
How did you hear about us?
Who may we thank for recommending us, if applicable?

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Dr. Cannon is committed to providing exceptional care for you.
To optimize your healthcare, it is important that we have a full understanding of your child as an individual.

Please take your time to complete this questionnaire thoroughly and thoughtfully.
If you are uncomfortable answering any questions, you may leave those blank
to be further discussed during your child's appointment.

~

Health Concerns: please list in order of importance with date of onset:

Describe your child's main concern (symptoms, impact on your life, etc.):

When did this main concern begin? _____

Has your child received medical care or other treatments for this? Y / N

If yes, please describe:

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Medical History

Please list your child's current medical diagnoses:

Diagnosis	When diagnosed	Medication/treatment and effect

List any past hospitalizations, surgeries or traumas in your child's life, including dates:

_____

_____

List any major illnesses in your child's life, including dates:

_____

_____

List any recurrent illnesses:

_____

_____

Please indicate if your child has had any of the following conditions:

	Abscesses		Asthma		Bronchitis		Cancer		Chicken pox
	Croup		Epilepsy		Measles		Mononucleosis		Mumps
	Parasites		Pneumonia		Rheumatic fever		RSV		Sepsis
	Skin problems		Tonsillitis		Warts		Worms		
	Frequent colds								
	Ear infections, and if so how many:								

Other: _____

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Has your child had any of the following tests:

Electroencephalogram Y / N When: _____ Result: _____
X-ray Y / N When: _____ Result: _____
Psychological evaluation Y / N When: _____ Result: _____
Hearing tests Y / N When: _____ Result: _____
Speech or language tests Y / N When: _____ Result: _____
Other tests/imaging: _____ When: _____ Result: _____

Birth History

At approximately how many weeks of pregnancy was your child born? _____weeks

Weight at birth: _____ Length of labor: _____ APGAR (if known): _____

Complications: _____

What is your child's blood type? (If unknown, leave blank.) _____

Please indicate if your child had any of the following problems shortly after birth:

	Birth defects		Birth injury		Blue baby		Cerebral palsy		Colic
	Fever		Jaundice		Rash		Seizures		

Other: _____

Vaccinations

	Chickenpox		DTaP		Hib		Influenza		MMR
	Polio		Pneumococcal		Rotavirus		Tetanus		

Others:_____

Any adverse reactions: Y / N If Yes, please describe: _____

Do you follow a standard vaccination schedule for your child? Y / N
If No, please describe your approach to this:

_____

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Allergies:

Any allergies to foods? Y / N

Any allergies to environment, including seasonally? Y / N

Any allergies to medications? Y / N

If yes to any allergies above, please describe what and your child's reaction:

_____

_____

_____

Medications + Supplements
List ALL prescriptions, over-the-counter medications and supplements your child is taking.
Include any herbal, homeopathic, hormonal, and nutritional (vitamins/minerals) products.

Medication, Supplement, etc.	Reason	Dosage	Date Began	Effective (Y/N)

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Lifestyle

What is your and your child's current living situation?

Who else lives in your home?

Do you feel comfortable and safe in your living situation? Y / N
Does your child (as far as you know)? Y / N
If no to either of the above, please describe:

Do you have any pets? Y / N If yes, what? _____

Are you aware of any stressors for your child at home, school or elsewhere? Please describe.

Does your child play sports or exercise? Y / N

If yes, please describe:

What are your child's interests and hobbies?

Please describe your child in 5 words.

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Describe a typical day of food (with honesty and no judgement - include everything you typically eat).

Breakfast: Time: _____

Lunch: Time: _____

Dinner: Time: _____

Snacks: Time(s): _____

Desserts: Time(s): _____

Drinks (water, juice, soda, tea, coffee, etc.): Time(s): _____

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Have you noticed any adverse reactions to food? If yes, please describe:

Are you concerned with drug or alcohol use by your child? Y / N

If Yes, please describe:

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Review of Systems **C = current; P = past; N = never**

General			Teeth grinding	☐ C ☐ P ☐ N
Weight loss or gain	☐ C ☐ P ☐ N		Canker sores	☐ C ☐ P ☐ N
Night sweats	☐ C ☐ P ☐ N		Dental fillings	☐ C ☐ P ☐ N
Fever	☐ C ☐ P ☐ N		Breath odor	☐ C ☐ P ☐ N
Chills	☐ C ☐ P ☐ N		**Neck**	
Head			Swollen gland	☐ C ☐ P ☐ N
Frequent Headaches	☐ C ☐ P ☐ N		Pain or stiffness	☐ C ☐ P ☐ N
Migraines	☐ C ☐ P ☐ N		**Respiratory and Chest**	
TMJ, jaw pain or clicking	☐ C ☐ P ☐ N		Frequent cough	☐ C ☐ P ☐ N
Head injury	☐ C ☐ P ☐ N		Shortness of breath	☐ C ☐ P ☐ N
Eyes			Asthma	☐ C ☐ P ☐ N
Glasses or Contacts	☐ C ☐ P ☐ N		Wheezing	☐ C ☐ P ☐ N
Vision loss or impairment	☐ C ☐ P ☐ N		Phlegm	☐ C ☐ P ☐ N
Excess tears / watery eyes	☐ C ☐ P ☐ N		Bronchitis	☐ C ☐ P ☐ N
Dry eyes	☐ C ☐ P ☐ N		**Cardiovascular**	
Ears			Heart disease	☐ C ☐ P ☐ N
Ear infection	☐ C ☐ P ☐ N		Heart murmur	☐ C ☐ P ☐ N
Change in hearing	☐ C ☐ P ☐ N		Fainting	☐ C ☐ P ☐ N
Nose and Sinus			Rheumatic fever	☐ C ☐ P ☐ N
Loss or change in smell	☐ C ☐ P ☐ N		**Gastrointestinal**	
Sinus infection or pain	☐ C ☐ P ☐ N		Nausea	☐ C ☐ P ☐ N
Hayfever or allergies	☐ C ☐ P ☐ N		Vomiting	☐ C ☐ P ☐ N
Congestion	☐ C ☐ P ☐ N		Belching	☐ C ☐ P ☐ N
Nose bleeds	☐ C ☐ P ☐ N		Passing gas/flatulence	☐ C ☐ P ☐ N
Mouth and Throat			Constipation	☐ C ☐ P ☐ N
Frequent sore throat	☐ C ☐ P ☐ N		Diarrhea	☐ C ☐ P ☐ N

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Heartburn	❑ C ❑ P ❑ N	Broken bones	❑ C ❑ P ❑ N
Jaundice	❑ C ❑ P ❑ N	Muscle spasms or cramps	❑ C ❑ P ❑ N
Gallbladder disease	❑ C ❑ P ❑ N	**Neurological**	
Average number of bowel movements/day: _____		Seizures	❑ C ❑ P ❑ N
Urinary		Dizziness	❑ C ❑ P ❑ N
Increased frequency	❑ C ❑ P ❑ N	Numbness or tingling	❑ C ❑ P ❑ N
Incontinence/leakage	❑ C ❑ P ❑ N	Loss of balance	❑ C ❑ P ❑ N
Bed-wetting	❑ C ❑ P ❑ N	Easily stressed	❑ C ❑ P ❑ N
Skin		**Vascular**	
Rashes	❑ C ❑ P ❑ N	Easy bleeding, bruising	❑ C ❑ P ❑ N
Hives	❑ C ❑ P ❑ N	Anemia	❑ C ❑ P ❑ N
Frequent itching	❑ C ❑ P ❑ N	**Sleep**	
Acne, boils	❑ C ❑ P ❑ N	Sleep problems	❑ C ❑ P ❑ N
Eczema	❑ C ❑ P ❑ N	Difficulty falling asleep	❑ C ❑ P ❑ N
Psoriasis	❑ C ❑ P ❑ N	Frequent waking	❑ C ❑ P ❑ N
Endocrine		Nightmares	❑ C ❑ P ❑ N
Fatigue	❑ C ❑ P ❑ N	Average number of sleep hours/night: _____	
Intolerance to heat or cold	❑ C ❑ P ❑ N	Difficulty waking in A.M.	❑ C ❑ P ❑ N
Excessive thirst	❑ C ❑ P ❑ N	**Mental/Emotional**	
Excessive hunger	❑ C ❑ P ❑ N	Mood swings	❑ C ❑ P ❑ N
Low blood sugar	❑ C ❑ P ❑ N	Anxiety	❑ C ❑ P ❑ N
High blood sugar	❑ C ❑ P ❑ N	Irritability	❑ C ❑ P ❑ N
Thyroid problems	❑ C ❑ P ❑ N	Hyperactivity	❑ C ❑ P ❑ N
Autoimmune disease	❑ C ❑ P ❑ N	Cries easily	❑ C ❑ P ❑ N
Musculoskeletal		Fearful	❑ C ❑ P ❑ N
Joint pain or stiffness	❑ C ❑ P ❑ N	Motion or car sickness	❑ C ❑ P ❑ N

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Females only, if applicable

Age of first menses: _____ Duration of menses (blood flow), on average: _____ days

Length between cycles, average (length from start of menses to start of next menses): _____ days

Female Systems: **C = current; P = past; N = never**

Painful menses	☐ C ☐ P ☐ N		Bleeding between cycles	☐ C ☐ P ☐ N
Heavy or excessive flow	☐ C ☐ P ☐ N		PMS symptoms	☐ C ☐ P ☐ N
Irregular cycles	☐ C ☐ P ☐ N			

Any other conditions:

_____

_____

_____

Males only, if applicable

Male Systems: **C = current; P = past; N = never**

Hernia	☐ C ☐ P ☐ N		Difficulty urinating	☐ C ☐ P ☐ N
Testicular pain	☐ C ☐ P ☐ N		Testicular masses	☐ C ☐ P ☐ N

Any other conditions:

_____

_____

_____

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Family History

Please fill in the information below to the best of your knowledge and as applicable.

Relation	**Medical Conditions**	**Age if living**	**Age at death**	**Cause of death**
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Sibling:				
Sibling:				
Sibling:				
Other:				
Other:				

If there is anything else you would like to mention at this time, please share below.

Thank you for taking the time to complete this form.
We look forward to seeing you soon!