

Child Intake Form

Personal Information

Date: _____

Name of child: _____ Sex: M F Age: _____ Birth Date: _____

Name of parent/guardian: _____

Address: _____

City: _____ Province: _____ Postal code: _____

Telephone (Home): _____ (Work): _____ (Cell): _____

Email: _____

Preferred contact for appointment reminders: email phone

Child's other health care providers:

	1	2	3
Name			
Occupation or Specialty			
Address			
Phone			
Fax			

In case of emergency, contact: _____ Relationship: _____ Phone: _____

How did you hear about the clinic? _____ Who can we thank? _____

Have you seen a Naturopathic Doctor before: Yes No If yes, for what ailment(s)? _____

Current History:

What are your child's health concerns in order of importance?

1. _____
2. _____
3. _____
4. _____

Has anything changed recently or become worse?

Medication and Supplement History

Please list all supplements, herbs, and medications your child is currently taking:

Medication/Supplement	Dosage	Since	Reason

When was the last time he/she used antibiotics? _____ Reason: _____

How many times (approx) has he/she used antibiotics in his/her life? _____

Does your child have any allergies (medicines, environmental, etc.)?

Please list any past medications/supplements:

Medication/Supplement	Time taken	Reason

Health History

How would you describe your child's general state of health: Excellent Good Fair Poor

Please indicate the childhood diseases that your child has had. Include whether it was mild, average, or severe.

Disease	Age	Severity	Disease	Age	Severity
Asthma			Pertussis (whooping cough)		
Chickenpox			Pneumonia		
Eczema			Rheumatic fever		
Fifth's disease			Roseola		
Frequent ear infections			Rubella (German measles)		
Mononucleosis			Scarlet fever		
Mumps			Strep throat		

Please list any other serious conditions, illnesses, injuries, fractures, hospitalizations (any health history!):

Condition/illness/injury or hospitalization	Date	Complications or long term consequences?

Please indicate what immunizations your child has had:

- DPT (diphtheria, pertussis, tetanus)
 Haemophilus influenza B
 Hepatitis A
 Tetanus booster. When: _____
 "Flu"
 Hepatitis B
 MMR (measles, mumps, rubella)
 Polio
 Smallpox or Chickenpox
 Other: _____ Any adverse reactions? _____

Prenatal Health

What was the health of the mother during pregnancy?: Excellent Good Fair Poor Unknown

How was the mother's diet during pregnancy?: Excellent Good Fair Poor Unknown

What was the mother's age at the child's birth?_____ Father's age at birth?_____

Did the mother already have other children? No Yes; If yes, how many:_____

Did the mother experience any of the following during pregnancy?

- Bleeding
 High Blood Pressure
 Nausea
 Vomiting
 Diabetes
 Thyroid problems
 Physical or emotional trauma
 Other:_____

Did the mother use any of the following during pregnancy?

- Alcohol
 Tobacco
 Recreational drugs:_____
 Prescription medications:_____
 Over the counter medications:_____
 Supplements:_____

Birth history:

Term length: Full Premature: _____ wks Late:_____ wks

Was the birth: Vaginal C-section Induced Forceps Anesthesia used

Length of labour:_____ Weight at birth:_____ Any complications?_____

Did the child experience any of the following at or shortly after birth?

- Jaundice
 Rashes
 Seizures
 Birth injuries
 Birth defects:_____
 Other:_____

How was your child fed as an infant?

Breastfed. How long? _____

Formula: Milk Soy Other

When did they begin eating solid foods? _____

Family History

Please indicate whether your child's family members have, or have had the following:

Illness	Relative	Illness	Relative
Alcoholism		Diabetes	
Allergies		Drug abuse	
Alzheimer's disease		Heart disease	
Arthritis		High blood pressure	
Asthma		Kidney disease	
Cancer (indicate type)		Osteoporosis	
Mental illness		Suicide	
Liver disease		Other familial disease	

Gastrointestinal Health

How often does your child have a bowel movement? _____

Does he/she tend towards: Constipation Diarrhea Both Neither

Has he/she had blood in your stool? Yes No Mucus? Yes No Black, tarry stool? Yes No

Does he/she have gas? Yes No Bloating? Yes No Heartburn? Yes No

Diet

Does your child have any food allergies or intolerances? _____

How much water does he/she drink per day? _____

Please jot down your child's typical diet in a day:

Breakfast	Lunch	Dinner	Drinks/Snacks

Lifestyle/Environment

Does your child sleep well? Yes No On average, how many hours per night? _____

Does your child experience: Bed-wetting Hyperactivity Tantrums Nightmares Growing pains

Disobedient behaviour Stomach pains Other: _____

Is your child exposed to significant tobacco smoke (work, home, etc)? Yes No

Is your child frequently exposed to animals (work, pets, etc)? Yes No

Is your child regularly exposed to toxins or other hazards? Yes No Which ones? _____

How would you describe your child's temperament? _____

What household stressors has your child witnessed or experienced? _____

How would you describe the emotional climate of your home?

What kind of physical activities do they enjoy? _____

How many hours of television do they watch per day? _____ Daily computer hours? _____

Was there anything missed on this form that you would like to address?

I thank you - and your health thanks you - for taking the time filling out this form! It will bring insight to your intake and treatment plan.