Family Naturopathic Clinic

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CHILD INTAKE FORM:

Name: _____ Sex: M/F Age: _____
Date of Birth: (MM/DD/YYYY) _____ Place of Birth: _____
Street Address:_____
City: _____ Province: _____ Postal Code: _____
Mother's Phone: _____ Email: _____
Father's Phone: _____ Email: _____
Emergency Contact Person and Telephone Number:
_____

Referred by: _____
Mother's Name and Occupation: _____
Father's Name and Occupation: _____
Parents are (circle): Married Separated Divorced Living Together
Grade in School: _____

Has your child been seen by other doctors for the same concern? Yes _____ No _____
Pediatrician's name and telephone number:
_____
Last time your child had blood work done: _____

What are your child's health concerns, in order of importance:
1. _____
2. _____
3. _____
4. _____
5. _____

Please list all surgeries and hospitalizations along with approximate dates.
1. _____
2. _____
3. _____

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

List all medicines (prescription or over the counter) the child is on now and has been on in the past:

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

List all the supplements the child is taking:

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

List all known allergies to foods, drugs, the environment, and animals.

_____

Previous Medical History: Check Yes or No, if yes write how many times.

Condition	Yes	No	Number of times
Ear Infection			
Colds			
Strep Throat			
Rubella/German Measles			
Measles			
Chicken pox			
Mumps			
Roseola			
Impetigo			
Scarlet Fever			
Whooping cough			
Mononucleosis			

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

Vision tests normal: Yes _____ No _____ Not tested _____
Hearing tests normal: Yes _____ No _____ Not tested _____
Speech impediments: Yes _____ No _____ In past _____
Learning impediments: Yes _____ No _____ In past _____

Family Health History:

Allergies: Yes _____ No _____ Obesity: Yes _____ No _____
Cancer: Yes _____ No _____ Tuberculosis: Yes _____ No _____
Mental Illness: Yes _____ No _____ Cardiovascular Disease: Yes _____ No _____
Do either of the parents have a chronic illness? If yes, please describe:

_____

Pregnancy History:

Age of father at conception _____ Age of mother at conception _____
Health of father at conception _____
Health of mother at conception and during pregnancy:
_____
Did the mother already have other children? _____
Diet of mother during pregnancy: Excellent Good Fair Poor

Questions for mother during pregnancy	Yes	No
Did the mother use supplements?		
Medications?		
Did the mother smoke?		
Use drugs?		
Alcohol?		
Did the mother experience bleeding?		
Have high blood pressure?		
Have nausea?		
Vomit?		
Have diabetes?		
Thyroid problems?		
Physical or emotional trauma?		

Length of labour: _____
Vaginal birth: Yes ___ No ___, C-Section: Yes ___ No ___, Induced: Yes ___ No ___
Traumatic birth? Yes ___ No ___
If the birth was difficult, please explain: _____
_____

Term length: Full Premature: _____wks Late: _____wks

Health History of Child:

Breastfed: Yes ____ No ____ If yes, how long? _____
What kind of formula was used? Milk/Soy/ Other: _____
When was child put on formula? _____
When did child begin eating solid foods? _____
When did child first begin to crawl? _____ walk? _____
When did child first begin to talk? _____
Develop teeth? _____

Condition	Yes	No	Condition	Yes	No
Jaundice as a baby			Colic		
Cradle cap			Diaper rash		
Eczema and/or Psoriasis			Asthma		
Diarrhea			Constipation		
Finicky eater			Warts		
Poor teeth			Bed-wetting		
Hyperactivity			Chronic sniffles		
Nightmares			Tantrums		
Anemia			Disobedient		
Stomach pains			Growing pains		

How would you describe your child's temperament? _____
_____
_____

How would you describe your child's behavior and performance at school?
_____
_____

What household stressors has your child witnessed or experienced?
1. _____
2. _____
3. _____

How would you describe the emotional climate of your home?
_____
_____

What kind of physical activities does your child enjoy?
_____

How often does your child play outside? _____
How much television does your child watch per day? _____
How many hours is your child on the computer daily? _____

Does your child participate in any religious group? Yes ____ No ____
Is your child an active participant? Yes ____ No ____
What religion does your child practice? _____

<u>Toxin Exposure:</u>
Does anyone in the child's home smoke? Yes ____ No ____

How is your house heated? _____

Has your child ever lived near a factory or polluted area, or in a home with lead paint? If so, what kind of pollution was your child exposed to?

_____

_____

Has your child ever lived in a house with new carpeting, paint, cabinets, or renovations that seemed to affect their health at all?

_____

Does your child seem especially sensitive to perfumes, gasoline, or other vapours?

_____

Do you spray pesticides, herbicides, or other chemicals around your home?

_____

Are there any animals in the house? Yes ____ No ____ What kind? _____

Thank you for taking the time to fill out this health questionnaire.
It will greatly help in the study of your child's present health concerns
and will assist in optimizing their health.