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CONFIDENTIAL CHILD INTAKE FORM

DATE: _____

PATIENT INFORMATION:

Child's Full Name: _____

Date of Birth: MM / DD / YY Gender: _____ Person Filling Out Form: _____

EMERGENCY CONTACT INFORMATION:

Name of Contact: _____ Relationship to Child: _____

Address: _____ Home Phone: _____

_____ Business Phone: _____

_____ Mobile Phone: _____

_____ E-mail Address: _____

Preferred Contact: ☐ Home ☐ Business ☐ Mobile ☐ E-mail ☐ Other: _____

OTHER HEALTH CARE PROVIDERS:

My child is seeing/has seen a…	Date of Last Visit	Practitioner's Name and Contact Information
☐ Pediatrician		
☐ Medical Specialist		
☐ Other:		
☐ Other:		
Approximate date of child's last physical exam:		
Does your child get regular screening tests done by another doctor (blood tests, etc.)? ☐ Yes ☐ No		

GENERAL HEALTH QUESTIONNAIRE:

Is this your child's first time seeing a Naturopathic Doctor? ☐ Yes ☐ No

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

What are the health concerns that brought you to our clinic today? Please list them in order of importance to you along with an approximate date or age that the condition began.

Health Concerns	Date/Age of Onset
1.	
2.	
3.	
4.	
5.	

MEDICATIONS AND SUPPLEMENTS:

Please list all your child's current medications (prescription and over-the-counter) and supplements (vitamins, herbs, homeopathics, etc.):

Medication or Supplement	Dose, Frequency and Duration	Reason for Taking it

ALLERGIES AND SENSTIVITIES:

Please list all allergies and sensitivities that your child experiences (environmental, food, drugs, etc.):

Allergic Substance	Reaction Experienced

FAMILY HEALTH HISTORY: ☐ I don't know my child's family medical history

Please indicate if any relatives currently have (or have had in the past) any of the following conditions:

Condition	Mother	Father	Sibling	Grandparent	Aunt	Uncle	Other Relative (Please Specify)
Allergies							
Asthma							
Birth Defects							
Juvenile Arthritis							
Heart Disease							
Diabetes							
Kidney Disease							
Cancer							
High Blood Pressure							
Anemia							
Celiac Disease							
Depression							
Other Mental Illness							
Substance Abuse							
Other Conditions: _____ _____							

COMPREHENSIVE HEALTH HISTORY:

Please indicate if your child has had any major injuries, surgeries, and hospitalizations:

Major Injury/Surgery/Hospitalization	Approximate Date or Age

How many times has your child been treated with antibiotics in the past year? _____

Please indicate which of the following illnesses your child has had:

☐ Rubella (German measles) ☐ Mumps ☐ Measles ☐ Scarlet Fever ☐ Whooping cough

☐ Roseola (Sixth Disease) ☐ Impetigo ☐ Chickenpox ☐ Mononucleosis ☐ Asthma

☐ Eczema ☐ Frequent Infections (Strep Throat, Ear Infections, Cold or Flu, etc.)

☐ Other: _____

Please indicate which of the following vaccinations your child has had:

☐ DPT (diphtheria, pertussis, tetanus) ☐ Tetanus booster ☐ Hepatitis A (Traveller's Vaccine)

☐ Haemophilus influenza B ☐ Smallpox ☐ Hepatitis B

☐ MMR (measles, mumps, rubella) ☐ Chickenpox ☐ Tuberculosis

☐ Influenza ("Flu" shot) ☐ Polio ☐ Other: _____

Did any of these cause an adverse reaction? Please explain: _____

_____

PRENATAL HEALTH:

Mother's Health:

Mother's age at child's birth: _____

	Poor	Fair	Good	Excellent	Unknown
Health at conception	☐	☐	☐	☐	☐
Health through pregnancy	☐	☐	☐	☐	☐
Nutrition during pregnancy	☐	☐	☐	☐	☐

Father's Health:

Father's age at child's birth: _____

	Poor	Fair	Good	Excellent	Unknown
Health at conception	☐	☐	☐	☐	☐

Did the parents use any fertility treatments to conceive? ☐ Yes ☐ No

Did the mother receive prenatal care? ☐ Yes ☐ No

Did the mother have a history of miscarriage? ☐ Yes ☐ No

Did the mother experience any of the following *during* pregnancy:

☐ Bleeding ☐ Nausea ☐ Vomiting ☐ Physical or Emotional Trauma

☐ High Blood Pressure ☐ Diabetes ☐ Thyroid Problems ☐ Other: _____

Did the mother use any of the following *during* pregnancy:

☐ Tobacco ☐ Alcohol ☐ Recreational Drugs: _____

☐ Medications: _____

☐ Supplements: _____

BIRTH HISTORY:

Gestational term: ☐ Full term ☐ Premature (_____ weeks) ☐ Late (_____ weeks)

Length of labour: _____ Weight at birth: _____

Any complications? : _____

Was the birth: ☐ Vaginal ☐ C-Section ☐ Induced ☐ Forceps Used ☐ Anesthesia Used

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

☐ Jaundice ☐ Rashes ☐ Seizures ☐ Birth injuries: _____ ☐ Birth defects: _____

DIET:

How was your infant fed? ☐ Breastfed – How long? _____ ☐ Formula (Milk, Soy, Other): _____

What foods were introduced before 6 months? Please list the approximate month that food was introduced.

_____

_____

_____

What foods were introduced between 6 and 12 months?

_____

_____

_____

Did your child ever experience colic? ☐ Yes ☐ No If yes, how severe? ☐ Mild ☐ Moderate ☐ Severe

Does your child have any dietary restrictions (religious, vegetarian, vegan, gluten-free, etc.)?

_____

_____

Describe a typical day's diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (and total quantity) _____

HEALTH AND DEVELOPMENT:

How was your child's health in the first year? ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Unknown

At what age did your child first:

Sit up _____ Crawl _____ Walk _____ Talk _____

Describe your child's sleep pattern: _____

_____

How would you describe your child's temperament and behaviour?

_____

_____

_____

ENVIRONMENT AND SAFETY:

With whom does the child live? _____

Is the child in: ☐ School (Grade: _____) ☐ Daycare ☐ Home Care ☐ Other: _____

Does the child exercise regularly? ☐ Yes ☐ No What type and how often? _____

How many hours per day does your child spend in front of a screen (television, computer, or other electronic devices)? _____

How often does your child read for leisure (not for school), or how often does someone read to your child?
☐ Daily ☐ Several times a week ☐ Weekly ☐ Less than weekly

Does anyone in the household smoke? ☐ Yes ☐ No

Are there any pets (cats, dogs, etc.) in the home? ☐ Yes ☐ No

Has your child even been exposed to any known or suspected toxic substance? Please describe:

_____

_____

How is your home heated? (Gas furnace, electrical heating, etc.) _____

Thank you for taking the time to carefully fill out this extensive intake form.
If there is anything that you feel is important that has not been covered, please feel free to attach the information on a separate piece of paper. If available, please bring any copies of laboratory/imaging reports or any medical documentation to your first visit. I look forward to working with you!