Roots Up Nutritional Consulting
for your nutritional needs from the roots up

CLIENT INTAKE FORM – CHILDREN

(all questions are optional)

DATE: _____

NAME: _____ BIRTHDATE:_____

ADDRESS: _____

City/Province: _____ Postal Code: _____

PHONE: (home) _____ (cell) _____

EMAIL: _____

HOW DID YOU HEAR ABOUT ROOTS UP NUTRITIONAL CONSULTING?

_____

Client Statement:

I understand and acknowledge that the services hereby provided are at all times restricted to consultation on the subject of health matters intended for general well-being and are not meant for the purposes of medical diagnosis, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. This statement is being signed voluntarily.

Date: _____

Signature: _____

Name (please print): _____

REASON FOR YOUR CHILD HAVING THIS NUTRITIONAL CONSULTATION:

(List your child's symptoms or condition you would like improved or treated in this consultation)

_____

_____

_____

_____

_____

CURRENT HEALTH HISTORY:

List any medications your child is currently taking:

Is your child allergic to anything? (Ex. foods, medications, pollens, chemicals, moulds, animal hair):

Which vitamins or other nutritional supplements is your child taking?
Include dosages:

Is your child currently seeing any other health practitioners? (acupuncturist, chiropractor, physiotherapist, counsellor, etc.):

Has your child had any medical test or investigations lately? (Include reason for test and results):

Has your child been immunised? (Did they have a reaction to any of the vaccines?):

I feel that my child has not felt well since..... (Ex. a particular event, illness, loss or trauma):

Is your baby having any problems breastfeeding?

How many times a year does your child get a cold of flu?

How many courses of antibiotics has your child had? (When was the last course taken?)

Does your child suffer from any of the following conditions?:

- ☐ Diabetes
- ☐ ADD/ADHD
- ☐ Learning Difficulties
- ☐ Recurrent Tonsillitis
- ☐ Epilepsy
- ☐ Migraines
- ☐ Behavioural Problems
- ☐ Recurrent Ear Aches and Ear Infections
- ☐ Cancer
- ☐ Headaches
- ☐ Asthma
- ☐ Overweight

Give details and symptoms of the above conditions (how long has your child had condition, frequency, what makes symptoms better or worse, treatments and if successful):

Is your child a late developer? (Ex. crawling, teething, walking):

SLEEP AND ENERGY LEVELS:

Does your child have any problems getting to sleep or staying asleep? Explain.

List any possible causes of your child's sleeping problems. (Ex. scared of the dark, frequent nightmares, worrying about something happening at school).

Does your child wake up at certain times during the night? (Explain possible cause -- to go to the toilet, wet the bed, thirsty, nightmares, breast or formula feed)

What are your child's energy levels like?

Does your child have an energy slump at a particular time of the day or night?

Does you child feel tired and lethargic after eating?

DIET DIARY:

Fill out the following diet diary in as much detail as possible.
(Include portions, roughly the time of each meal, and breast or formula feeds if relevant):

What does your child eat and drink during a normal day?
Breakfast:

Mid-morning snacks:

Lunch:

Afternoon snack:

Dinner:

Dessert:

Before bed snack:

ADDITIONAL DIETARY INFORMATION:

My child is:

☐ Vegetarian ☐ Vegan

List any other foods your child eats regularly:

List any foods that your child dislikes and won't eat:

How much water does your child drink daily?

Is your child constantly thirsty?

How many juices does your child have a day?
What type? (ex. freshly squeezed, bottled, 100%, added sugar, or fruit drink)

Does your child drink soft drinks? (what type and how often)

Does your child crave any foods? List:

Is your child a fussy eater? Explain:

Does your child have a large or small appetite?

Do you add salt to your child's meals?

Do you add sugar or honey to any of your child's beverages? (Daily quantity):

DIGESTIVE HEALTH:

My child is:

- ☐ Allergic to Milk Protein
- ☐ Lactose Intolerant
- ☐ Wheat Intolerant
- ☐ Gluten intolerant (Celiac)

Does your baby suffer form colic? (Explain what makes it better or worse. Ex. rubbing or lying on stomach, at night or in the morning, bending legs up, arching back?):

Does your child experience bloating and flatulence? (Ex. after eating certain foods) Explain:

Does your child complain of recurrent stomach aches?
(Explain. Ex. after eating certain foods, particular time of day?)

Does your child complain of feeling nauseous or vomiting?
(ex. after eating certain foods, a particular time of day?) Explain:

Does your child suffer from constipation?
(ex. how often, after eating certain foods, when stressed) Explain:

Does your child complain of pain or straining when having a bowel movement?

Does your child suffer from diarrhoea?
(ex. how often, after eating certain foods, when stressed?) Explain:

How many bowel movements (or dirty diapers) does your child have a day?

Describe your child's stool:

- ☐ Hard
- ☐ Contains Mucous
- ☐ Light, Clay Colour
- ☐ Like Small Pebbles
- ☐ Dark Brown
- ☐ Undigested Food Particles
- ☐ Loose and Watery
- ☐ Mustard Yellow
- ☐ Green
- ☐ Contains Blood (□Bright or □Dark Red)

Do you feel that your child is overweight or underweight? (Or your baby is not gaining weight adequately?) Explain:

ORAL HEALTH:

Does your child suffer from any of the following?:

- ☐ Mouth Ulcers
- ☐ Bleeding Gums
- ☐ Dental Problems
- ☐ Other: _____
- ☐ Ulcers
- ☐ Oral Thrush
- ☐ Abscess

Give symptoms of the above conditions:

Is your child teething at the moment?

Is your child suffering from any of the following teething symptoms?:

- ☐ Chewing on Things
- ☐ Excessive Dribbling
- ☐ One Cheek Red and Flushed
- ☐ Both Cheeks Red and Flushed
- ☐ Cries A Lot, Irritable & Unsettled
- ☐ Waking More Frequently During the Night

Does your child grind their teeth?

Does your child have a white coating on their tongue?
(What colour? ex. white/cream/yellow/green/gray and thickness?)

EAR AND EYE HEALTH:

Does your child suffer from any other following conditions?

- ☐ Recurrent Ear Infections
- ☐ Hearing Problems
- ☐ Other: _____
- ☐ Tinnitus (ringing ears)
- ☐ Perforated ear drum

Give details and symptoms of the above condition:
(How long has your child had condition, frequency, what makes symptoms better or worse, treatments and if successful?):

Does your child have any eye problems?

- ☐ Conjunctivitis
- ☐ Itchy Eyes
- ☐ Other: _____
- ☐ Styes
- ☐ Dark Circles Around Eyes

NOSE AND RESPIRATORY:

Does your child suffer from any of the following respiratory conditions?
hay fever (allergic rhinitis -- seasonal or all year round?)

- ☐ Asthma
- ☐ Sinusitis
- ☐ Bronchitis
- ☐ Other: _____
- ☐ Wheezing
- ☐ Pneumonia
- ☐ Breathlessness on exertion

Give details and symptoms of the conditions above:
(How long has your child had condition, frequency, what makes symptoms better or worse -- pollens/foods/animal hair/time of year, treatments and if successful):

_____

_____

Does your child have nosebleeds often?
(Include possible cause, how often and when did they start):

_____

_____

Does your child have any of the following symptoms?

- ☐ Clear Nasal Discharge
- ☐ Cream Nasal Discharge
- ☐ Green Nasal Discharge
- ☐ Thick Nasal Discharge
- ☐ Loss of Appetite
- ☐ Sore Throat
- ☐ Cough (hard, dry, ticklish? Describe:_____)
- ☐ Productive Cough (What Colour:_____)
- ☐ Unproductive Cough
- ☐ Aching Muscles
- ☐ Nose Runs Like a Tap (Worse When?: □All day □Outside)
- ☐ Blocked Nose (Worse When?: □Night □All Day/Night)

URINARY SYSTEM HEALTH:

Does your child urinate (or have wet diapers) regularly?

_____

_____

I have noticed that my child's urine is:

- ☐ Clear Colour
- ☐ Dark Yellow Colour
- ☐ Offensive Smell
- ☐ Contains Blood

Does your child suffer from recurrent urinary tract infections?
Explain how often, symptoms and treatment:

Does your child wet the bed? How often and when did this start?

SKIN HEALTH:

Does your child suffer from any of the following?:

- ☐ Eczema
- ☐ Psoriasis
- ☐ Tinea
- ☐ Itchy Scalp
- ☐ Warts
- ☐ Dermatitis
- ☐ Cradle Cap
- ☐ Hives
- ☐ Diaper Rash
- ☐ Itchy Skin on Body
- ☐ Other: _____

Describe the symptoms above:
(How long has your child had the condition, what makes symptoms better or worse, what treatments have you tried, where on the body, describe how their skin looks)

EMOTIONAL HEALTH:
Explain your child's usual temperament:

What situations, foods or beverages trigger emotional reactions in your child? Explain:

Does your child have any fears or phobias? Explain:

_____

_____

Please indicate whether your child exhibits any of the following behaviours:

- ☐ Regular Temperament
- ☐ Clingy, Want to be Held All The Time
- ☐ Highly Competitive
- ☐ Fear of Failure
- ☐ Lacks Confidence
- ☐ Must Follow a Routine
- ☐ Stressed and Anxious
- ☐ Destructive
- ☐ Violent, Fights
- ☐ Always Sad
- ☐ Short Attention Span
- ☐ Cries When Put Down
- ☐ Perfectionist
- ☐ Very Sensitive
- ☐ Stubborn
- ☐ Independent
- ☐ Shy
- ☐ Outgoing
- ☐ Cries a Lot
- ☐ Argumentative
- ☐ Hyperactive
- ☐ Misbehaves at School

How is your child performing at school?

_____

_____

PAST HEALTH HISTORY:

Describe mother's health during pregnancy (did she suffer from anemia, gestational diabetes or hypertension?):

_____

_____

Did your child have a traumatic birth or were there any complications? Explain:

_____

_____

What childhood illnesses has your child had?:

- ☐ Chicken Pox
- ☐ Measles
- ☐ Other: _____
- ☐ Scarlet Fever
- ☐ Rubella
- ☐ Glandular Fever

Please list any other of your child's other health events, including viruses, injuries, hospitalisations, and operations in the time-line below:

0-1 years:

1-2 years:

2-3 years:

3-4 years:

4-5 years:

5-10 years:

10+ years:

PARENT'S HEALTH HISTORY:

Are you or your partner allergic to anything?

Are either of your child's parents lactose intolerant?

Are either of your child's parents gluten intolerant?

Do either of your child's parents suffer from eczema, hay fever, or asthma? Explain:

If breastfeeding, list foods you eat in a normal day. Include beverages:

List any known diseases or illnesses in your family such as diabetes, cancer, heart disease, or mental illness.

ADDITIONAL INFORMATION:

Is there anything else you would like to mention that you think may be affecting your child's health?

ONLINE NUTRITIONAL CONSULTATION CONSENT FORM

Holistic nutrition views the body as a whole and every body is a specialized, independent organism with biochemical individuality. Each client is dealt with on an individual basis. Holistic nutrition incorporates not only the body, but also the mind and spirit as well.

A holistic nutritionist will help educate you about the best food and lifestyle choices for your child. They will help you understand the truth about real food and wellness, and help you make the right choices to find your child's optimum self.

At times, natural medicines are recommended in order to stimulate the body's inherent healing capacity. A number of different approaches are used, such as dietary changes, nutritional supplements, herbs, homeopathic remedies, and lifestyle changes.

Natural remedies are generally considered safe and side effect free. Although rare, negative reactions to these natural medicines can occur, such as an allergic reaction to an herb or an aggravation to pre-existing symptoms. Natural medicines should be used with caution when treating some conditions such as in pregnancy, diabetes, heart and liver disease. It is very important, therefore, that you inform your RNCP immediately of any disease process that your child is suffering from.

I understand that a record will be kept of my child's personal health history. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that the nutritionist will answer any questions I have to the best of their ability. I understand that results are not guaranteed. I do not expect the naturopath to be able to anticipate and explain all risks and complications. I will rely on them to exercise judgment during the course of the procedure which they feel at the time is in my child's best interests, based upon the facts then known.

I have fully read and understand the above information and with this knowledge, I hereby consent to having an online nutritional consultation.

Signature: _____

Date: _____