Naturopathic Child Intake Form

Child's Name: _____ Date:_____

Date of Birth: _____(M/D/Y)

Parent(s) or Guardian(s) Name:_____

Address: _____Unit#:_____

City:_____ Province: _____ Postal Code:_____

Email address:_____

Telephone number: Home:_____Work:_____Cell:_____

Occupation:_____ Marital Status:

May we leave messages relating to your child's visits? Y/N Which number?_____

Emergency contact: Name:_____

Phone number(s):__(___)_____or_(___)_____ Relation:_____

How did you hear about the clinic? Please check one of the following:

	A patient of the clinic (please provide name):		Advertising (newspaper, brochure)
	My Medical Doctor/Specialist (please provide name):		Social Media (Facebook, Twitter, etc.)
	Other healthcare provider (please provide name):		Inspire Health and Wellness Website
	Information Session		Other:

Other Healthcare Providers you are seeing:
Name:_____ Name:_____ Name:_____

Specialty:_____ Specialty:_____ Specialty:_____

Phone #:_____ Phone #:_____ Phone #:_____

Date of last visit:_____ Date of last visit:_____ Date of last visit:_____

When was your child's last physical examination? _____

Health Goals

What are your child's health concerns? Please list them in order of significance.

- _____
- _____
- _____
- _____
- _____

Medical History

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

Please indicate any serious health conditions, illnesses or injuries, and any hospitalizations your child has experienced; along with approximate dates.

- _____
- _____
- _____

Does your child have any allergies (eg. medicines, environmental, etc.)? If so please list them.

Please list all current medications your child is taking, **including dosage details** (prescription, over the counter, natural remedies, supplements, vitamins, homepathics, etc.)

Please list past prescription medications/natural health products (including antibiotics and when they were taken)

- _____
- _____

Please indicate how many times your child has taken antibiotics:_____

Has your child ever experienced an adverse reaction to a medication or natural health product? If yes, please specify what and the extent of the reaction:_____

Please indicate what immunizations your child has had:

☐DPT (diphtheria, tetanus, pertussis) ☐Haemophilus Influenza B ☐Hepatitis A
☐Tetanus booster? When?_____ ☐"Flu" ☐Hepatitis B
☐MMR (measles, mumps, rubella) ☐Polio ☐Smallpox
Other:_____

Please list any adverse reactions to immunizations:_____
_____

Has your child had any of the following conditions? Please check all that apply.

☐Abscesses	☐Epilepsy	☐Parasites	☐Sunstroke
☐Asthma	☐Headaches(recurring)	☐Pleurisy	☐Tonsillitis
☐Allergies	☐Heart Disease	☐Pneumonia	☐Thyroid Disease
☐Anemia	☐Hepatitis	☐Psoriasis	☐Tuberculosis
☐Bronchitis	☐High Blood Pressure	☐Rheumatic Fever	☐Typhoid
☐Cancer	☐Influenza	☐Roseola	☐Whooping Cough
☐Chicken Pox	☐Kidney Disease	☐Rubella (German Measles)	☐Warts
☐Cold Sores	☐Leukemia	☐Scarlet Fever	☐Worms
☐Constipation (chronic)	☐Measles	☐Sexual Abuse	☐Yellow Fever
☐Diabetes	☐Migraines	☐Skin Disease	☐Other
☐Ear infection (frequent)	☐Mononucleosis	☐Sinusitis	☐
☐Emphysema	☐Mumps	☐Strep Throat	

Prenatal Health

How was the health of the child's parents at conception?
Mother: ☐Excellent ☐Good ☐Fair ☐Poor ☐Unknown
Father: ☐Excellent ☐Good ☐Fair ☐Poor ☐Unknown

How was the health of the mother during pregnancy?
☐Excellent ☐Good ☐Fair ☐Poor ☐Unknown

What was the mother's age at the child's birth? _____
Did the mother receive prenatal medical care? Y/N or Unknown

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

Did the mother experience any of the following during pregnancy?

☐Bleeding	☐Eclampsia	☐Thyroid Problems	☐Pre-eclampsia
☐Diabetes	☐High Blood Pressure	☐Physical/Emotional Trauma	☐Severe Vomiting

Did the mother use any of the following during pregnancy?
Tobacco/Alcohol/Antibiotics/Recreational drugs/over the counter medications/prescription medications

If yes to any of the above please specify amount and duration:_____
_____

Birth History
Term length: ☐Full ☐Premature; how many days?_____ ☐Late; how many days?_____
Length of labour?_____ hours Weight at birth?_____
☐Vaginal ☐C-section
Please specify any complications?_____

Did your child experience, or was diagnosed with, any of the following shortly after birth?

☐Jaundice	☐Seizures	☐Birth Defects
☐Rashes	☐Birth Injuries	☐Genetic Disorder

Diet
Was your child breastfed? Y/N If yes, how long?_____
Was your child formula-fed? Y/N If yes, how long and what kind of formula?_____

What foods were introduced before 6 months? Please list approximate month if possible.
- _____
- _____
- _____

What foods were introduced between 6-12 months? Please list approximate month if possible.
- _____
- _____
- _____

Has your child ever experienced colic? Y/N
If yes, was it: ☐Mild ☐Moderate ☐Severe

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

Typical Daily Diet

Breakfast:_____
Lunch:_____
Dinner:_____

Snacks:_____

Beverage Intake: Water:_____cups/d Juice:_____cups/d Soft drinks:_____cups/d
Specific cravings? (eg. sugar or salt)_____
Food Allergies/Intolerances:_____
How are your child's bowel movements? (eg. number per day) _____

Health and Development
At what age did your child first: sit up_____ crawl_____walk _____talk _____
How many hours does your child sleep overnight?_____
What time does your child go to sleep?_____pm
What time does your child wake up?_____am
Does your child have night terrors/nightmares?_____

Describe your child's temperament?_____
_____

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

Has your child ever experienced a physical, emotional, or psychological trauma? Y/N
If yes, please describe:_____
_____

Family History
Select any of the following that apply to a close relative (parent, sibling, grandparent)

Ailment	Who? What age?	Ailment	Who? What age?
☐Allergies		☐Depression	
☐Asthma		☐Juvenile Arthritis	
☐Heart disease		☐Kidney disease	
☐High Blood Pressure		☐Seizure disorder	
☐Diabetes		☐Birth defects	
☐Neurological disorders (MS, Parkinson's, etc.)		☐Other	

☐I don't know the family medical history

Environment

Has your child ever been exposed to toxic chemicals, solvent sprays, pesticides, herbicides, heavy metals (eg. lead, mercury, dental amalgams, cadmium, arsenic, etc.) while at school, home or traveling? Y/N

If yes, please specify what: _____

Is the child in: ☐Daycare ☐School ☐Homecare ☐Other:_____

Describe the emotional climate of your child's home and school to your knowledge:
_____
_____

Does your child get exercise? Y/N If yes, how often and what type(s)?_____
_____

How many hours per day does your child watch television?_____
How many hours per day does your child play video games?_____

Does anyone in the household smoke? Y/N
Are there animals in the home? Y/N

Are there any other toxins or hazards that the child is exposed to regularly (eg. home, school, hobbies)?
Please describe: _____
_____
_____

Is there anything that you feel is important to discuss that has not already been covered?

- _____
- _____
- _____