Naturopathic Child Intake Form

Date:_____

Child's First Name:_____ Last Name:_____

Date of Birth: (MM/DD/YYYY)_____Age: _____Sex: Male ☐ Female ☐

Parent/Guardian(s) Information:

Name:_____ Relation:_____

Street Address:_____

City:_____ Province:_____ Postal Code:_____

Telephone: Home: _____

Work: _____

Cell: _____

Email Address:_____

How do you prefer to be contacted? _____

Emergency Contact Name:_____

Emergency Contact Number:_____

How did you hear about the clinic?_____

Child's Health Information:

Current Health Care Providers:

1. _____Phone:_____
2. _____Phone:_____
3. _____Phone:_____

What is your child's MAIN concern (reason for visit)?

_____

_____

When did it start?_____

What makes it better?_____

What makes it worse?_____

What medications or treatments have you tried?_____

_____

Please list other health concerns you have for your child at this time:

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

MEDICATIONS/ SUPPLEMENTS

Please list CURRENT medications and/or supplements:_____

_____

_____

_____

_____

_____

Please list PAST medications and/or supplements: :_____

_____

_____

_____

_____

PRENATAL HISTORY

Mother's age at child's birth:_____ Father's age:_____

Number of previous pregnancies by natural mother, miscarriages, or complications:_____

Please check any of the following conditions if they were present during the pregnancy:

☐ Bleeding ☐ Nausea ☐ Vomiting ☐ Flu ☐ Edema (swelling) ☐ Hypertension ☐ Diabetes ☐ Drug Use ☐ Physical trauma ☐ Emotional trauma ☐ Caffeine Use ☐ Herpes ☐ Alcohol Abuse ☐ German measles ☐ Thyroid problems ☐ Infections (yeast etc.) ☐ Fainting ☐ Smoking ☐ Second hand smoke exposure

Medication Use:_____

Vitamin/Homeopathic/Herb Use:_____

_____

Other:_____

BIRTH HISTORY

Length of gestation (pregnancy):_____

Length of labour: _____ Spontaneous? _____ Induced? _____How?_____

Type of delivery (please check): ☐ Vaginal ☐ C-Section ☐ Emergency C-Section

Interventions used (please check): ☐ Anesthesia ☐Epidural ☐Episiotomy ☐ Forceps ☐ Other _____

Child's Weight at birth: _____ Length: _____ APGAR score: _____

CHILD'S HEALTH HISTORY:

Please indicate which of the following your child has **NOW (N)** or in the **PAST (P)**

Allergies		Diarrhea		Mononucleosis	
Asthma		Ear Infections		Mood Swings	
Bad Breath		Easy Bruising		Mumps	
Balance Problems		Eczema		Nausea	
Bed Wetting		Fever		Nervousness	
Bladder Infections		Flu		Night Sweats	
Body Odour		Fractures		Nose Bleeds	
Bronchitis		Frequent Urination		Physical Trauma	
Broken Bone		Fungal Infections		Pneumonia	
Canker Sores		Growing Pains		Sleeping Problems	
Chicken pox		Hair Loss		Speech Problems	
Cold		Headaches		Stomach Aches	
Constipation		Hearing Trouble		Strep Throat	
Cough		Impetigo		Tonsillitis	
Croup		Learning Disabilities		Unusual Fears	
Cradle Cap		Lice		Vision Problems	
Chronic Sore Throats		Measles		Walking Problems	
Crawling Problems		Meningitis		Warts	

VACCINATION HISTORY

Please indicate which of the following vaccinations your child has received and please include approximate dates:

☐ DPT (Diphtheria, Pertussis, Tetanus):_____

☐ Tetanus booster:_____

☐ MMR (Measles, Mumps and Rubella):_____

☐ Hepatitis A:_____

☐ Hepatitis B:_____

☐ HiB (Haemophilus Influenza B):_____

☐ Polio:_____

☐ Flu Shot:_____

☐ H1N1 Swine Flue Shot:_____

☐ Other_____

Has your child had any adverse reactions after a vaccination? (Please check)

☐ Excessive crying ☐ Pain ☐ Swelling ☐ Mood changes ☐ Limping ☐ Rash

☐ Loss of appetite ☐ Vomiting ☐ Insomnia ☐ Change in behavior ☐ Fever

☐ Other (Please list): _____

NUTRITIONAL HISTORY

Was the child breastfed within the first 10 hours after birth? Y/N

What kind of formula was used (if any)? Dairy, Soy, Goat, Rice, Other

Briefly outline your child's typical daily diet:

Breakfast:_____

Lunch:_____

Supper:_____

Snacks:_____

Fluids/Water:_____

Supplements:_____

GENERAL HEALTH

Does your child sleep through the night?_____ Hours of sleep: _____

Do you think your child could use more sleep? _____

Does your child wake refreshed? ☐ Yes ☐ No

Does your child nap? ☐ Yes ☐ No How long? _____

Please list all known allergies (include foods, environmental and medications): _____

_____

_____

Please list previous surgeries/hospitalizations/injuries (include dates if possible):_____

_____

_____

How would you describe your child's temperament? _____

How do they handle stress? _____

How does your child express their emotions? _____

Has your child experienced any emotional traumas? _____

Has your child experienced any abuse (sexual/physical/mental)?_____

Is your child exposed to second hand smoke? ☐ Yes ☐ No

Are there any smokers in your home? ☐ Yes ☐ No

Is there any mould in your home? ☐ Yes ☐ No Any pets? ☐ Yes ☐ No

FAMILY HISTORY

	Main Health Concerns (or if applicable, cause of death)

Mother	
Father	
Brother(s)	
Sister(s)	
Children	
Maternal Grandmother	
Maternal Grandfather	
Paternal Grandmother	
Paternal Grandfather	

~Thank-you for filling out this lengthy questionnaire, it is a valuable tool in understanding your child's health history~