Child Under 12 Years Old Intake Form

Please complete this form before your child's first visit

Note: some questions will not apply depending on your child's age

Child's Name:____________________________ **Date of Birth**: ____________ (MM/DD/YYYY) **Gender**: M F

Today's Date: _________________________

Who is filling out this form? ___________________________ **Relationship to child**: _______________

Contacts: (in order of preference)

Name: ______________________________ **Phone** (H) _______________________

Relationship to child: ___________________________ Phone (W): ______________________

Address: _______________________________________ Phone (other): ____________________

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Name: ______________________________ **Phone** (H) _______________________

Relationship to child: ___________________________ Phone (W): ______________________

Address: _______________________________________ Phone (other): ____________________

____

With whom does the child live? ____

May we leave messages relating to your visits? Y N **If yes, which number?** ________________

Other health care providers seeing your child:

1. __________________________ 2. _________________________ 3. _________________________

__________________________ _________________________ _________________________

__________________________ _________________________ _________________________

(____)_____________________ (____)____________________ (____)____________________

How did you hear about our clinic? ____

What are your child's health concerns in order of importance?

1. ____. First noticed: ______________

2. ____. First noticed: ______________

3. ____. First noticed: ______________

4. ____. First noticed: ______________

5. ____. First noticed: ______________

Please list two or three expectations you have from your Naturopathic Doctor *on the first visit*:

____

____

Please describe the *long-term* expectations that you have from your Naturopathic Doctor:

____

____

Medical History

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

Please indicate any serious conditions, illnesses or injuries and any hospitalizations, along with approximate dates.

____

____

Does your child have any allergies? (medicines, environmental, foods, etc.?)

____

Please list all current medications (prescription, vitamins, herbs, homeopathics, etc.)

Medication/Supplement	Dose/day	How long	What for?

Please list past prescription medications ______________________________________

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

Please indicate what immunization (or groups) your child has had:

Infant and Toddler Group
- ❑ DTaP-Hib *(Diptheria, Tetanus, Pertusis, Haemophilus influenza b)*
- ❑ Pneumococcal-C
- ❑ Meningococcal-C

12 months and Older Group
- ❑ MMR, V *(measles, mumps rubella, Varicella-chicken pox)*
- ❑ Influenza (flu shot)
- ❑ Hepatitis A
- ❑ Hepatitis B

Other Group
- ❑ HPV *(Gardasil)*
- ❑ Other:________________

Please indicate if any immunizations caused adverse reactions: ______________________________

Which of the following has your child had? (n – never, m – mild, a – average, s – severe)

n m a s ear infections
n m a s chicken pox
n m a s roseola
n m a s measles
n m a s mumps
n m a s rubella (German measles)
n m a s impetigo
n m a s scarlet fever
n m a s whooping cough
n m a s mononucleosis
n m a s strep throat

What screening tests has your child had? (vision, hearing, etc.?) ______________________________

Prenatal Health

What was the health of the parents at conception? Poor Good Excellent Unknown

What was the health of the mother during pregnancy? Poor Good Excellent Unknown

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

Was the mother vegetarian? Y N Unknown

What was the mother's age at the child's birth? ______________

Did the mother experience any of the following during pregnancy?

- ❑ Bleeding
- ❑ Diabetes
- ❑ High blood pressure
- ❑ Thyroid problems
- ❑ Physical or emotional trauma
- ❑ *GBS* positive
- ❑ Other: ______________

Did the mother use any of the following during pregnancy?

Tobacco: Y N Alcohol Y N Recreational drugs: _________________________

Prescription medications: ____

Over-the-counter medications: ____

Supplements: ____

Birth History

Term length (weeks): ______________ **Length of Labour**: ___________ **Weight at birth**: _______

Medical interventions? (epidural, pitocin, antibiotics for GBS+, vacuum, forceps, etc.?):

____

Was the birth: Vaginal C-section

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

Jaundice? Y N Rashes? Y N Seizures? Y N Birth injuries? __________________

Birth defects? __________________________________ Other: ____________________________

Health and Development

Current weight:___________ **Height**: ___________

Describe your child's sleep pattern: ____

How would you describe your child's temperament? ______________________________________

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

____

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

Physical Activity

At what age did your child first:

Sit up: ______________ **Crawl**: _____________ **Walk**: _____________ **Talk**: _____________

How often does your child play outside? _________________ **For how long**: ________________

What types of exercise does your child enjoy participating in: ______________________________

____

Diet

How was your infant fed?

Breast fed. How long? __________________ Formula fed. (Milk, Soy, other?): ______________

Other: __________________

When did the first tooth erupt? ___________________

What foods were introduced before 6 months? (Please list approximate months)

____

How often did your child experience colic? ________________________________

How severe? Mild Moderate Severe

Is/was your child a fussy eater? Y N _______________________________________

Please list any food aversions:____

Does your child have any food allergies, intolerances or sensitivities? (Please list)

____

Do you have any dietary restrictions? (religious, vegetarian, etc.?) _________________________

Describe a typical day's diet (for children eating solid food):

Breakfast: ____

Lunch: ____

Supper: ____

Snacks: ____

Beverages: (and total quantity): ____

How often does your child eat out per week? ____________

What is their favourite eating establishment? __________________________________

Environment

Is the child in: School daycare homecare other: _____________________________

What are your child's favourite activities: ____

Hours spent watching TV, texting/cellphone or on the computer per day: ________ (Total Hours)

How often does your child read (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 home smoke? Yes No

Is the child exposed to significant environmental pollutants (strong scents, cosmetics, molds, herbicides/pesticides, etc.)? Yes No. **If yes, please describe**:

____

Are you frequently exposed to animals? Yes No **If yes, please list**:______________________

How would you describe the emotional atmosphere in the child's home: ____________________

Family History

Indicate if a close relative has any of the following (parent, sibling):

Condition	Please indicate family member	Age of onset?
ADD/ADHD		
Allergies		
Anxiety or Depression		
Asthma		
Alzheimer's Disease		
Arthritis		
Cancer		
Diabetes		
Digestive (Colitis, Crohn's, etc.)		
Drug or Alcohol abuse		
High Blood Pressure		
Heart Disease		
Kidney disease		
Skin Problems		
Other conditions/diseases:		

- ❑ I don't know the family history

Do either of the parents have a chronic illness? ____

Is there anything else that you feel is important that has not been covered?

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Would you like to learn more about (please check if interested):

- ❑ Botanical medicine
- ❑ Naturopathic spine/joint manipulation
- ❑ Nutritional counseling
- ❑ Western acupuncture applications
- ❑ Reasoning behind ND's in Canada attaining prescription rights