Child Intake

LEASE COMPLETE THIS FORM AND RETURN IT TO CLINIC RECEPTION
(Please print clearly)

Name of the child_____Date _____

Date of birth _____ (M/D/Y) Gender F M other_____

Who is filling out this form (name and relation to child)_____

Contact

Name_____ Relationship to child: _____

Address:_____

E-mail Address:_____

Telephone number: Home:_____ Work:_____ Cell:_____

With whom does the child live? _____

Have you ever consulted for your child (please circle all that apply)
Naturopathic doctor Acupuncturist Nutritionist Counselor

Health Goals

What are your health concerns and goals, in order of importance:

Please list most important health concerns and goals in their order of significance:	Prior diagnosis of this problem? If so, what?
1	
2	
3	

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.

1) _____4) _____

2) _____5) _____

3) _____6) _____

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

1) _____4) _____

2) _____5) _____

3) _____6) _____

Please list all current medications/natural health products (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

1) _____4) _____

2) _____5) _____

3) _____6) _____

Which screening tests has your child had (blood, hearing, vision, etc.)_____

Birth History

Term length: Full Premature: ____wks Late_____wks

Length of labour: _____ Weight at birth _____ Length at birth_____

Any complications? _____

Was the birth: Vaginal/C-section Induced Forceps Anesthesia used

Did the child experience any of the following at or shortly after birth?
Jaundice Rashes Seizures Birth injuries:_____

Birth defects:_____

How was your infant fed? Breastfed. How long? _____ Formula Milk/Soy/other:

Did your child ever experience colic? Yes No

Does your child have any food allergies or intolerances? Please list

_____

Does your child have any dietary restrictions (religious, vegetarian/vegan ect)?

_____

Environment

Is the child in: School Daycare Homecare Other_____

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?

_____

How much:

Television does your child watch? _____hours a day/week

Computer/tablet/smart phone time does your child have? _____hours a day/week

Video game time does your child play? _____hours a day/week

For file use only