

Child Intake Form

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held confidential. If you have questions, please ask. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the last section. Thank you.

Child's Name:		Date:	
Street Address (including apt number)		City	Province
Postal Code			
Age:	Height:	Weight:	Sex:
Home Phone:		Work Phone:	Email:
Parent/Guardian Name:		Occupation:	
Date of Birth (d/m/y):		Phone Number:	
Emergency Contact		Phone Number:	
Referred by:			
Family Medical Doctor:			
Other Health Care Providers			

What are your (your child's) health concerns, in order of importance to you:

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

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

Please list any serious conditions, illnesses or injuries, physical trauma, and any hospitalizations including approximate date.

Has there been any emotional trauma or event after which the child changed significantly or was never well since?

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

Please list all **current** medications your child is taking (prescriptions, over-the-counter, vitamins, herbs, homeopathic remedies, etc).

Please list **past** medications your child has taken.

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

Does your child frequently use any of the following?

Aspirin Laxatives Antacids Diet Pills Pop Caffeine-form and amount/day: _____

Please indicate what immunizations your child has had:

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> DPT (Diphtheria, Pertussis, Tetanus) | <input type="checkbox"/> Haemophilus Influenza B | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Tetanus Booster, when? _____ | <input type="checkbox"/> Influenza (flu) | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> MMR (measles, Mumps, Rubella) | <input type="checkbox"/> Polio | <input type="checkbox"/> Smallpox |
| <input type="checkbox"/> Chicken Pox Tuberculosis | <input type="checkbox"/> Other _____ | |

Please indicate if any caused adverse reactions:

Does your child get regular screening tests done by another doctor? (Blood tests etc) Yes No

DIET

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

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

Describe a typical day's diet: (include quantities)

Breakfast: _____
 Lunch: _____
 Dinner: _____
 Snacks: _____
 Beverages: _____

FAMILY HISTORY

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

- Alcoholism Allergies Asthma Cancer Depression Diabetes Epilepsy Gonorrhoea Hepatitis
Leukemia Pneumonia Syphilis Tuberculosis Heart Disease Hypertension Kidney Disease
Other: _____ I don't know my child's medical history

PRENATAL AND NEO NATAL

Were there any maternal health concerns before, during or immediately after pregnancy? If so, please describe:

Prenatal history (mother's health during pregnancy): Please circle and expand when necessary

Thyroid problem	Ultrasound
Gestational diabetes	Other interventions
Nausea	Emotional trauma
Vomiting	Drug Abuse
Toxemia	Alcohol abuse Smoking
Hypertension	Working situation
Anemia	Medication
Genital herpes	Supplements
Bleeding	Known toxic exposure
Other	

Age of mother at conception: _____ Age of father at conception: _____

Health of Father at conception: _____

Sibling's age and health status: _____

Child's Health at Birth:

Full term? <input type="checkbox"/> Yes <input type="checkbox"/> No	Premature? <input type="checkbox"/> Yes <input type="checkbox"/> No
Cesarean? <input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Birth <input type="checkbox"/> Yes <input type="checkbox"/> No
Induced labour? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other interventions? <input type="checkbox"/> Yes <input type="checkbox"/> No
Length of labour?	Location of labour?
Weight	Length
APGAR score	Jaundice
Early infection	Anemia
Others	

Were any medications/herbs/remedies used at delivery?

Neonatal health history: (first 2 months)

Any early medical interventions (what, result, reaction)?

Illness: (circle them)

Infections Anemia Colic Jaundice Rashes Respiratory Distress Other?

Medication was used, effect and reaction?

How long did the baby stay in the hospital after birth?

Was your child breast-fed? Yes No

If yes, for how long? _____

Was your child bottle-fed? Yes No

If yes, for how long? _____

What type of formula? Yes No

Was cow's milk used? Yes No

Does your child drink cow's milk now? Yes No If yes, how much? _____

At which age was food introduced? _____

Which foods were first? _____

Are there family pets? Yes No

If yes, please list: _____

Developmental Milestones (give age in months up to 2 years old):

Rolling over		Standing		First teeth		Runs Well	
Holds head up		Crawling		Talking		Catches ball	
Sitting up		Walking		Climb stairs			

Check any of the following the child may have had:

Measles		Asthma		Ear infection		Bedwetting	
Mumps		Whooping cough		Eye problem		Kidney infection	
Rubella		Strep Throat		Hearing problem		Parasites	
Chicken pox		Tonsillitis		Growing pain		Meningitis	
Warts		Pneumonia		Constipation		Allergies	
Eczema		Bronchitis		Diarrhea		Difficult teething	
Cradle cap		Hay Fever		Digestion problem		Anemia	
Diaper rash		Frequent colds		Hernia		Slow growth	
Thrush		Sinusitis		Appendicitis		Sleep Problem	

ENVIRONMENTAL

Hobbies: _____

Does your child exercise regularly? Yes No

If yes, what type, how much and how often? _____

Is your child exposed to significant tobacco smoke? Yes No

How is your home heated? _____

Is your child regularly exposed to toxins or other hazards (school, home, hobbies, etc)? Please describe: _____

How would you describe the emotional climate of your home?

How stressful is school, or other aspects of your child's life? How well does your child handle these stressed? Is your child bullied?

In general, does the child feel hot or cold? _____

What does the child fear?

How is the child's appetite? Any food cravings or aversions? _____

What is the child's mood generally?

What is the child's personality?

Who takes care of the child all day? _____

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