Date: _____

Naturopathic Essentials Health Centre

Confidential Child Intake Form (0 – 12 yrs)

CHILD'S NAME: First: _____ Last: _____ Middle: _____

SEX (√): _____ **BIRTHDATE (Month/Day/Year):** _____ **AGE:** _____

Mother's Name: _____ **Father's** Name: _____

HOME ADDRESS: _____

Phone work: _____ Phone home: _____

Email: _____ Cellphone: _____

Emergency Contact:_____ Phone: _____

How did you hear about us? ☐ Referral ☐ Just Walking By ☐ Google Ads ☐ Internet Search ☐ Other:_____

*If you were referred to us by a friend or family member, please give us their name so we may send them a letter of appreciation. _____

**We send newsletters on health issues and other information mailings to all our patients. If you do NOT want to be part of the mailing list, please check here: "No thank you" __

OTHER HEALTH PROVIDER(S) INFORMATION

Pediatrician:_____ Phone: ( )_____

Other Health Care Provider(s): _____ Phone: ( )_____

_____ Phone: ( )_____

Do you have extended medical coverage? _____

WHAT ARE YOUR CHILD'S HEALTH CONCERNS (in order or importance)

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

ALLERGY INFORMATION

Does your child have any allergies to any drugs, supplements, herbs, foods, animals or other?

_____

_____

CONTEXT OF CARE OVERVIEW

1. Why did you choose to come to this clinic?

What do you know about our approach?

2. What three expectations do you have from this visit to our clinic?

What long term expectations do you have from working with our clinic?

What expectations do you have of me personally as your/ your child's physician?

3. What is your/ your child's present level of commitment to address any underlying causes of your/ your child's signs and symptoms that relate to your/ your child's lifestyle? (Rate from 0 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

4. a) What behaviours or lifestyle habits do you/ your child currently engage in regularly that you believe support your health? (please list)

b) What behaviours or lifestyle habits do you/ your child currently engage in regularly that you believe are self destructive lifestyle habits? (please list)

5. What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your/ your child's health and in adhering to the therapeutic protocols which we will be sharing with you?

6. Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you/ your child will be making?

7. What does your child LOVE to do?

PREGNANCY

Complications with Pregnancy:

☐ Toxemia ☐ Diabetes ☐ High blood pressure ☐ Vomiting ☐ Nausea
☐ Bleeding ☐ Thyroid Problems ☐ Trauma (physical or emotional) ☐ Other (Please specify)

Mother & Father's Ages at Conception: _____

Length of Pregnancy: ☐ Full Term ☐ Premature _____ wks ☐ Late _____ wks

Number of Previous Pregnancies: _____

Any past miscarriages or abortions? When? _____

Pregnancy Care: ☐ Medical doctor ☐ Doula ☐ Midwife ☐ Other (please specify): _____

Health of mother during pregnancy (physical & emotional states):

_____

_____

Prescription Medications/ Over the counter/ Supplements/ Herbs/ Homeopathics taken during pregnancy:

_____

_____

Please describe your diet during the pregnancy. Indicate cravings also. _____

_____

How much weight did you gain? _____

Labour & Delivery History

Place of Birth: ☐ Hospital ☐ Home ☐ Other (please specify):_____

Birth Weight:_____ Birth Length:_____ Duration:_____

Type of Birth: ☐ Vaginal ☐ C-Section ☐ Breech ☐ Forceps ☐ Suction ☐ Induced
☐ Anaesthesia & Medications used _____

Complications experienced by child after birth (√):

☐ Jaundice ☐ Birth defects / Injuries ☐ Rashes
☐ Seizures ☐ Respiratory problems ☐ Other (please specify):

Mother's Profile:

Age: _____ Present Health Status (circle): Excellent / Good / Fair / Poor

Occupation: _____ FULL-TIME / PART-TIME (circle)

Smoker: Yes / No During Pregnancy: Yes / No (anyone in household)

Alcohol (drinks/week?): _____ During Pregnancy: Yes / No

Recreational Drugs: Yes / No During Pregnancy: Yes / No

What is your present stress level? Please rate on a scale of 1 (least) to 10 (most). _____

Father's Profile:

Age: _____ Present Health Status (circle): Excellent / Good / Fair / Poor

Occupation: _____ (circle) FULL-TIME / PART-TIME

Smoker: Yes / No During Pregnancy: Yes / No

What is your present stress level? Please rate on a scale of 1 (least) to 10 (most). _____

Child's Profile:

A. MEDICAL HISTORY

Please indicate the immunizations your child has had. Check this box if he/she has received all on schedule without any side effects: **(√) " ☐ "**

Vaccination	**Age Received**	**Date(s) of each Immunization**	**Reactions or Side-Effects**
DPT (diphtheria, pertussis, tetanus)			
Tetanus booster			
MMR (measles, mumps, rubella)			
Haemophilus influenza B			
Hepatitis A			
Hepatitis B			
Smallpox			
Polio			
Flu shots			

Other immunizations: _____

Hospitalizations / Surgeries (specify)_____

Current and Past Medications and Supplements (please list & indicate dose, for how long):

_____

_____

B. DEVELOPMENTAL MILESTONES (list age):

Sitting _____ Crawling _____ Walking _____ Talking _____ Teething _____

Fully-toilet trained _____

C. FEEDING / NUTRITIONAL HISTORY:

Breast fed for how long? _____

Formula at what age? _____ What kind (milk, soy, other): _____

Food Introduction Schedule:

Age (month & yr) of Food Introduction.				
Type of Food (fruit, veggies, meat, etc) Introduced				

Describe your child's appetite:

_____

Please describe <u>your child's most regular foods</u> OR <u>yesterday's</u> diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages (type and amount?): _____

Which foods does your child crave? _____

D. SLEEP:

When does your child go to bed? _____ What time does he/she wake up? _____

Does the child wake up at night? Yes / No How often? _____ Nightmares?_____

Any difficulty sleeping? Yes / No Does your child take naps? Yes / No

E. FAMILY HISTORY (include allergies, chronic & inherited conditions, etc) :

Relative	Condition(s)
Mother	
Father	
Sibling #1	
Sibling #2	
Sibling #3	
Sibling #4	
Grandparents	
Other	

Position of child in family: _____

Number of people in the home: _____

F. PSYCHOSOCIAL HEALTH:

Child's Hobbies and Activities Enjoyed:

_____

_____

How often does your child watch TV/ play video games?(fill in # & circle day or wk) ___ hrs a day/ wk

Is your child in: (Circle) School Daycare Other _____ Grade: _____

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

_____

Is your child active or exercise regularly? Yes / No If yes, specify type, length & frequency of activity:

_____

G. ENVIRONMENT & HOME PROFILE

Place of Residence (ie. basement apartment, etc) and length of stay there: _____

Found in your household (√): ☐ Air Filters ☐ Carpets ☐ Pets ☐ Smoke ☐ Other potential hazards _____

Other caregivers for the child: _____

What is the emotional setting of your child's environment?

At home: _____

REVIEW OF SYSTEMS

Circle any symptom(s) your child has experienced and put an "**N"** beside it if currently experiencing it **Now** or **"P"** if in the **Past**.

General: headache fever/ chills fatigue/ weakness dizziness

Hair and Scalp: dandruff lice cradle cap itchiness hair loss

Skin: infections rashes scaling bruising bleeding jaundice

Eyes: infections blurred vision eyeglasses (nearsighted, farsighted)
squinting color blindness

Ears: infection discharge wax decreased hearing foreign objects

Nose, throat, sinuses: runny nose colds decreased smell foreign objects
bloody nose tonsillitis

Mouth: cavities gingivitis cleft lip

Respiratory: bronchitis pneumonia asthma cough sputum

Cardiovascular: heart murmurs cyanosis palpitations rheumatic fever

Gastrointestinal: nausea vomiting diarrhea constipation
colic gas blood/black stools

Urinary: increased frequency urgency burning bedwetting
odor blood in urine hesitancy

Male Reproductive: hernias testicular mass testicular pain penile discharge

Female Reproductive: menses vaginal itching vaginal discharge

Neuromuscular: seizures muscle weakness numbness tremors imbalance

Blood/ Lymphatics: anemia easy bleeding easy bruising swollen lymph node

Emotional: mood swings nervousness depression/ sadness

Thank you for taking the time to complete this form.