Child Intake

Please complete this form and return to reception. Please print clearly.

Demographic Information

Name of Child: ______________________________ Date: ____________ (MM/DD/YYYY)

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

Address: ____ Apt/Unit #: ________

City: __________________ Province: __________________ Postal Code: ____________

Home: (____) ____________ Work: (____) ____________ Cell: (____) ______________

May we leave messages relating to your visits? Y N Which Number: ______________

Who is completing this form (name and relation)? ________________________________

Contact(s) Information in Order of Preference

Name: ____ Relation: ______________

Address: ____ Apt/Unit #: ________

City: __________________ Province: __________________ Postal Code: ____________

Home: (____) ____________ Work: (____) ____________ Cell: (____) ______________

Name: ____ Relation: ______________

Address: ____ Apt/Unit #: ________

City: __________________ Province: __________________ Postal Code: ____________

Home: (____) ____________ Work: (____) ____________ Cell: (____) ______________

How did you hear about us? ____

Has your child ever consulted a complimentary health care practitioner? (please check all that apply)

Naturopathic Doctor Acupuncturist Homeopath Nutritionist Counsellor Dietician

Chinese Medicine Practitioner Other: ________________________________

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Other Health Care Providers that your child sees

Name: ______________________________________ Name: ______________________________________

Specialty: ___________________________________ Specialty: ___________________________________

Address: ____________________________________ Address: ____________________________________

Phone: (____)_________________________________ Phone: (____)_________________________________

What are your child's **health concerns**, **goals** and **expectations** for working with us? (in order of importance to you)

1.____

2.____

3.____

Medical History

Please indicate any **serious conditions**, **illnesses**, **injuries** and **hospitalizations** that your child has experienced (with dates):

1.____

2.____

3.____

Please list any **allergies** that your child has (medication, environmental, food, sensitivities):___________________________________

What screening tests has your child had (vision, hearing, blood, etc)? ____

Please list all current **medications** and **natural health products** (e.g. prescriptions, over the counters, vitamins, herbs, homeopathics)

Medications and Natural Health Products	Dose	Reason for Taking

How many times has your child been treated with **antibiotics**? ____________________________________

Please indicate which immunizations your child has had:

DPT (diphtheria, pertussis, tetanus)
Haemophilus influenza B
Hepatitis A
Hepatitis B
HPV
Rotavirus
Meningitis
Pneumococcal
MMR (measles, mumps, rubella)
Polio
Small pox
Other: ________________

Please indicate if there were any adverse reactions: ____

Birth History

Term length (please circle): Full Premature: ____________ weeks Late: __________weeks

Weight at birth: ______________________________ Birthing method: Vaginal C-section Induced Forceps Vacuum

Any complications? ____

How was your child fed?

Breastfed, how long? __________________ Formula milk/soy/other: _________

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

Health and Development

At what age did your child first:

Sit up: ________________ Walk: _______________________

Crawl: ________________ Talk: ________________________

Describe your child's **sleep pattern**: ____

Describe your child's **temperament**: ____

Describe your child's **behaviour** and **performance at school**: ____

Environment

Is your child in: School Daycare Homecare Other: ________________

What are your child's favourite activities?

____

____

Does the child get regular activity? Y N If so, what is it, how much and how often?

____

____

How much screen time does your child get each day (TV, computer, tablet)? ____

How often does your child read (not for school) or have someone read to them? ____

Does anyone in the child's household smoke? Y N Do they smoke around the child? Y N

How would you describe the emotional climate of your child's home?

____

____

Has your child experienced any of the following?

		If yes, please explain:
General (Failure to Gain Weight, Fatigue, Night Terrors)	Y / N	
Eyes/Head (Vision Changes, Headache, Dizziness)	Y / N	
Ear/Nose/Throat (Hearing Loss, Sinus Problems, Infections)	Y / N	
Thorax (Irregular Heartbeats, Murmur, Wheezing, Coughing, Asthma)	Y / N	
GI (Heartburn, Diarrhea, Constipation, Vomiting, Abdominal Pain)	Y / N	
Urinary (Frequent or Painful Urination, Incontinence, Blood in Urine)	Y / N	
MSK (Arthritis, Swollen Joints, Cramps, Stiffness, Weakness)	Y / N	
Skin/Hair/Nails (Rashes, Excessive Dryness, Sores, Itching, Hair Loss)	Y / N	
Neurological (Numbness, Tingling, Weakness, Paralysis)	Y / N	
Psychiatric (Depression, Anxiety, Bipolar Disorder, Temper Tantrums)	Y / N	
Endocrine (Excessive Hunger, Thirst, or Sweating, Thyroid Problems)	Y / N	
Hematological/Lymphatic (Anemia, Bruising, Bleeding Problems)	Y / N	
Female (Breast Development; If started Menses: Heavy /Painful, PMS)	Y / N	
Male (Testicular Pain/Lump)	Y / N	
Other:	Y / N	

What potential obstacles do you foresee when adhering to a therapeutic protocol or achieving your child's goals?

____

____

Family History

Please indicate all known, diagnosed medical conditions, illnesses and surgeries of any of the following family members: mother, father, grandmother, grandfather, siblings Please indicate if it is a current condition or a condition in the past.

Family Member	**Diagnosis**

I do not know my child's family medical history

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