

## Intake Form - Child

Please complete this form as thoroughly as possible. This information will be kept in strict confidentiality.

### SECTION 1 - GENERAL INFORMATION:

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Parent Telephone (home): \_\_\_\_\_ Parent Telephone (cell): \_\_\_\_\_

Parent Email address: \_\_\_\_\_ Parent Telephone (work): \_\_\_\_\_

Referred by: \_\_\_\_\_

### SECTION 2 - CURRENT MEDICAL INFORMATION:

Health Concerns:

Please list the health concerns that you wish to address:

	Health Concern:	How long has your child had this condition?
1		
2		
3		
4		

If your child has any severe allergies or medical conditions (eg. Anaphylaxis, Medications, Epilepsy) please list here:

\_\_\_\_\_

\_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Telephone: \_\_\_\_\_

Current Medications: Please list all prescribed medications that your child is currently taking:

Name/Brand:	Dose:	For what condition?	Since when?

Current Natural Health Products: Please list all supplements, botanicals, homeopathics, etc. that your child is currently taking:

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Please list any other allergies or hypersensitivities your child may have: \_\_\_\_\_

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What are your goals from treatment? \_\_\_\_\_

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**SECTION 3 - PAST MEDICAL INFORMATION:**

Medical History:

Please describe any major illnesses, hospitalizations, surgeries, accidents, injuries, etc. (including the date of occurrence and any problems experienced since then):

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Vaccination History: Please indicate any vaccinations your child has had:

- |                                                        |                                                                   |                                                                 |
|--------------------------------------------------------|-------------------------------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> MMR (measles, mumps, rubella) | <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus)     | <input type="checkbox"/> IPV (inactivated polio virus)          |
| <input type="checkbox"/> Varicella (chicken pox)       | <input type="checkbox"/> Hepatitis A or B or both (ie. – Twinrix) | <input type="checkbox"/> Influenza (flu shot)                   |
| <input type="checkbox"/> Meningitis                    | <input type="checkbox"/> HPV (human papilloma virus)              | <input type="checkbox"/> Other (rabies, typhoid, cholera, etc.) |

Was there any adverse reactions after receiving any of these vaccines?     NO     YES

If yes, please describe: \_\_\_\_\_

Describe any major ailments that have affected your child’s relatives: \_\_\_\_\_

Prenatal History:

Mother’s age at child’s conception: \_\_\_\_\_    Father’s age at child’s conception: \_\_\_\_\_

Parent’s health at conception (G=good, P=poor):    Mother: \_\_\_\_\_    Father: \_\_\_\_\_

Please check any of the boxes that apply if the Mother had any of the following concerns during the pregnancy:

- |                                          |                                               |                                           |
|------------------------------------------|-----------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Gestational diabetes | <input type="checkbox"/> Hypertension     |
| <input type="checkbox"/> Bleeding        | <input type="checkbox"/> Physical trauma      | <input type="checkbox"/> Emotional trauma |
| <input type="checkbox"/> Other: _____    |                                               |                                           |

Please check any of the boxes that apply if the Mother was exposed to any of the following during the pregnancy:

- |                                                                                    |                                   |                                             |
|------------------------------------------------------------------------------------|-----------------------------------|---------------------------------------------|
| <input type="checkbox"/> Cigarette smoke (1 <sup>st</sup> or 2 <sup>nd</sup> hand) | <input type="checkbox"/> Alcohol  | <input type="checkbox"/> Recreational drugs |
| <input type="checkbox"/> Environmental toxins                                      | <input type="checkbox"/> Caffeine | <input type="checkbox"/> Other: _____       |

Maternal Medications: List all prescribed medications taken during the pregnancy:

Name/Brand:	Dose:	For what condition?	Since when?

Maternal Natural Health Products: List all supplements, botanicals, homeopathics, etc. taken during the pregnancy:

Name/Brand:	Dose:	For what condition?	Since when?

Early Childhood History:

Child's gestational age at birth (please circle):

Pre-term (<37 weeks)

Full term (38-42 weeks)

Post-term (>42 weeks)

Vaginal birth?  Yes  No

C-section?  Yes  No

Was labour induced?  Yes  No

Were forceps or vacuum extraction used?  Yes  No

Were epidural or pain medication used?  Yes  No

Were there any other complications during delivery?  Yes  No

Length of labour: \_\_\_\_\_ Birth weight: \_\_\_\_\_

Was your child jaundice or anemic?  Yes  No

Any birth defects?  Yes  No

Difficulties feeding?  Yes  No

Child breast fed?  Yes  No If yes, for how long?: \_\_\_\_\_

Health History: Please check if your child has had any of the following:

- |                                                          |                                                      |                                              |
|----------------------------------------------------------|------------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Chicken Pox                     | <input type="checkbox"/> Rheumatic Fever             | <input type="checkbox"/> Nightmares          |
| <input type="checkbox"/> Measles                         | <input type="checkbox"/> Diphtheria                  | <input type="checkbox"/> Bed-wetting         |
| <input type="checkbox"/> Mumps                           | <input type="checkbox"/> Cradle cap                  | <input type="checkbox"/> Fears / Phobia      |
| <input type="checkbox"/> Eczema                          | <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Sweaty Baby / Child |
| <input type="checkbox"/> Diaper rash                     | <input type="checkbox"/> Chronic stuffy nose / colds | <input type="checkbox"/> Growing Pains       |
| <input type="checkbox"/> Ear infection                   | <input type="checkbox"/> Lice                        | <input type="checkbox"/> Slow to Walk        |
| <input type="checkbox"/> Poor teeth or teething problems | <input type="checkbox"/> Fifth's disease             | <input type="checkbox"/> Delayed speech      |
| <input type="checkbox"/> Strep throat                    | <input type="checkbox"/> Warts                       | <input type="checkbox"/> Early Puberty       |
| <input type="checkbox"/> Hyperactivity                   | <input type="checkbox"/> Colic                       | <input type="checkbox"/> Vision problems     |

Health History: (continued)

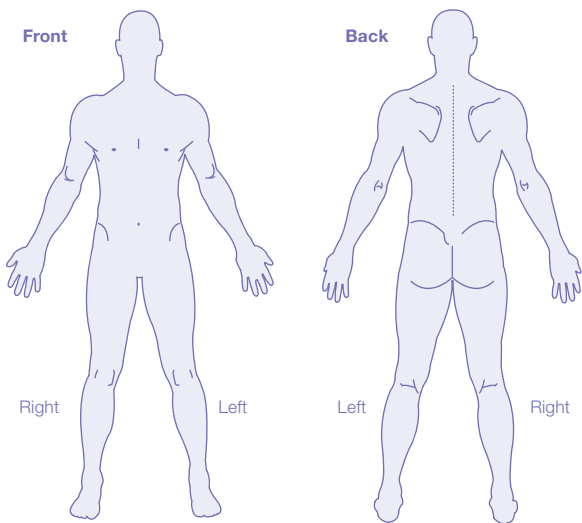
- |                                                |                                                  |                                          |
|------------------------------------------------|--------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Aggression            | <input type="checkbox"/> Irritability / Tantrums | <input type="checkbox"/> Diarrhea        |
| <input type="checkbox"/> Stomach aches         | <input type="checkbox"/> Thrush                  | <input type="checkbox"/> Constipation    |
| <input type="checkbox"/> Poor (or picky) eater | <input type="checkbox"/> Hearing problems        | <input type="checkbox"/> Vision problems |

Any particular household stressors your child has witnessed or gone through:

- 1) \_\_\_\_\_ 3) \_\_\_\_\_  
 2) \_\_\_\_\_ 4) \_\_\_\_\_

**SECTION 4 :**

Please shade areas of pain or discomfort on the body diagrams and make comments if necessary.



Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_