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:

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

What are your goals from treatment?

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):

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

- ☐ MMR (measles, mumps, rubella)
- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ IPV (inactivated polio virus)
- ☐ Varicella (chicken pox)
- ☐ Hepatitis A or B or both (ie. – Twinrix)
- ☐ Influenza (flu shot)
- ☐ Meningitis
- ☐ HPV (human papilloma virus)
- ☐ 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:

- ☐ Nausea/vomiting
- ☐ Gestational diabetes
- ☐ Hypertension
- ☐ Bleeding
- ☐ Physical trauma
- ☐ Emotional trauma
- ☐ Other: _____

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

- ☐ Cigarette smoke (1st or 2nd hand)
- ☐ Alcohol
- ☐ Recreational drugs
- ☐ Environmental toxins
- ☐ Caffeine
- ☐ 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

Where 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:

☐ Chicken Pox
☐ Measles
☐ Mumps
☐ Eczema
☐ Diaper rash
☐ Ear infection
☐ Poor teeth or teething problems
☐ Strep throat
☐ Hyperactivity
☐ Rheumatic Fever
☐ Diphtheria
☐ Cradle cap
☐ Asthma
☐ Chronic stuffy nose / colds
☐ Lice
☐ Fifths disease
☐ Warts
☐ Colic
☐ Nightmares
☐ Bed-wetting
☐ Fears / Phobia
☐ Sweaty Baby / Child
☐ Growing Pains
☐ Slow to Walk
☐ Delayed speech
☐ Early Puberty
☐ Vision problems

Health History: (continued)

- ☐ Aggression
- ☐ Irritability / Tantrums
- ☐ Diarrhea
- ☐ Stomach aches
- ☐ Thrush
- ☐ Constapation
- ☐ Poor (or picky) eater
- ☐ Hearing problems
- ☐ Vision problems

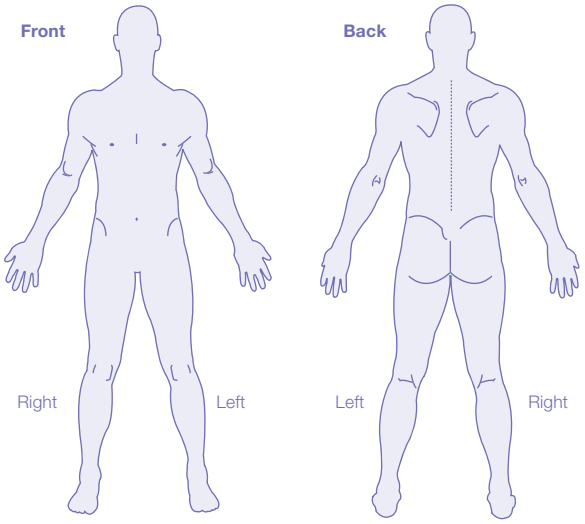
Any particular household stressors your child has witnessed or gone through:

1) _____ 3) _____

2) _____ 4) _____

SECTION 4 :

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



Comments: _____