

NATUROPATHIC CHILD INTAKE

Child's Name _____ Date of Birth _____ Sex _M_ F

Date _____ Referred By _____

Your Name and Relation to Child _____

Contact Information (IN ORDER OF PREFERENCE)

1. Name _____ Home Phone _____

Address _____ Work Phone _____

_____ Other _____

Relationship to Child _____

2. Name _____ Home Phone _____

Address _____ Work Phone _____

_____ Other _____

Relationship to Child _____

With whom does the child live? _____

Other Health Care Providers: (PLEASE INCLUDE TELEPHONE NUMBER)

What are your child's health concerns? Please name in order of importance:

1. _____

2. _____

3. _____

4. _____

5. _____

Medical History

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

Please indicate any serious conditions, illnesses, injuries, and any hospitalizations. Please provide dates if possible:

Which of the following has your child had? (n-never, m-mild, a-average, s-severe)

- Rubella n m a s Roseola n m a s Impetigo n m a s Measles n m a s
 Scarlet Fever n m a s Mononucleosis n m a s Chicken Pox n m a s
 Whooping Cough n m a s Ear Infections n m a s Strep Throat n m a s

Does your child have any allergies? (MEDICATIONS, ENVIRONMENTAL)

Please list all current medications: (PRESCRIPTION, OVER-THE-COUNTER, VITAMINS, HERBS, HOMEOPATHICS, ETC)

Please list past prescription medications:

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

Please indicate what immunizations your child has received:

- DPT (diphtheria, pertussis, tetanus) Haemophilus influenza B Hepatitis A Hepatitis B
 Tetanus Booster; when _____ "Flu" Polio
 MMR (measles, mumps, rubella) Other _____

Please indicate if any caused adverse reactions:

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

Prenatal Health

What was the health of the parents at conception?

- Mother POOR FAIR GOOD EXCELLENT UNKNOWN
Father POOR FAIR GOOD EXCELLENT UNKNOWN

What was the health of the mother during pregnancy?

- POOR FAIR GOOD EXCELLENT UNKNOWN

What was the mother's age at the child's birth? _____

How was the mother's diet during pregnancy?

- POOR FAIR GOOD EXCELLENT UNKNOWN

Did the mother receive prenatal medical care? YES NO UNKNOWN

Did the mother experience any of the following during the pregnancy?

- BLEEDING HIGH BLOOD PRESSURE
 NAUSEA VOMITING
 DIABETES THYROID PROBLEMS
 PHYSICAL OR EMOTIONAL TRAUMA
 OTHER _____

Did the mother use any of the following during the pregnancy?

- TOBACCO ALCOHOL RECREATIONAL DRUGS: _____
 PRESCRIPTION MEDICATIONS: _____
 OVER-THE-COUNTER MEDICATIONS: _____
 SUPPLEMENTS: _____
 OTHER: _____

Birth History

Term Length: FULL PREMATURE: ____ WEEKS LATE: ____ WEEKS

Length of Labour: _____ Weight at Birth _____

Any complications? _____

Was the birth: VAGINAL/C-SECTION INDUCED FORCEPS ANESTHESIA USED

Did the child experience any of the following at, or shortly after birth?

- JAUNDICE RASHES SEIZURES BIRTH INJURIES: _____
 BIRTH DEFECTS: _____
 OTHER: _____

Diet

How was your infant fed?

BREAST FED, HOW LONG _____ FORMULA/MILK/SOY/OTHER _____

OTHER: _____

What foods were introduced before 6 months? (PLEASE LIST APPROXIMATE MONTH)

6-12 months?

Did your child ever experience colic? _____ If yes, how severe? Mild Moderate Severe

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

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (and total quantity) _____

Health and Development

How was your child's health in the first year? POOR FAIR GOOD EXCELLENT

At what age did your child first:

Sit up _____

Crawl _____

Walk _____

Talk _____

Describe your child's sleep pattern: _____

How would you describe your child's temperament? _____

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

Family History

Indicate if a close relative (PARENT, SIBLING) has had any of the following:

Allergies _____ Diabetes _____

Asthma _____ Kidney Disease _____

Birth Defects _____ Juvenile Arthritis _____

Other _____

I don't know the family medical history

Do either of the parents have a chronic illness? If yes, please describe: _____

Environment

Is the child in: school daycare homecare other _____

What are your child's favourite activities? _____

Does your child exercise regularly? If yes, how often?

How much television does your child watch? _____ hrs a day/week.

How often does your child read (not for school), or how often does someone read to your child?

Daily Several times a week Weekly Less than weekly

Does anyone in the child's household smoke? _____

Are there animals in the home? _____

How is the child's home heated? _____

Do you know of any toxins or other hazards the child is regularly exposed to (HOME, OTHER'S WORK, HOBBIES, ETC)? Please describe:

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

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