CHILD INTAKE FORM

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the last section. Thank you.

Child's Name:		Date:	
Street Address (including apt number) City Province Postal Code			
Age:	Height:	Weight:	Sex:
Home Phone:	Work Phone:	Email:	
Parent/Guardian Name:		Occupation:	
Date of Birth (d/m/y):		Phone Number:	
Emergency Contact		Phone Number:	
Referred by:			
Family Medical Doctor:			
Other Health Care Providers			

What are your (your child's) health concerns, in order of importance to you:

1._____

2._____

3._____

4._____

5._____

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

Please list any serious conditions, illnesses or injuries, physical trauma, and any hospitalizations including approximate date.

_____

_____

_____

_____

Has there been any emotional trauma or event after which the child changed significantly or was never well since?

_____
_____
_____
_____

Does your child have any allergies (environmental, medicines, etc)?

_____
_____
_____
_____

Please list all ***current*** medications your child is taking (prescriptions, over-the-counter, vitamins, herbs, homeopathic remedies, etc).

_____
_____
_____
_____

Please list ***past*** medications your child has taken.

_____
_____
_____
_____

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

Does your child frequently use any of the following?
□Aspirin □Laxatives □Antacids □Diet Pills □Pop □Caffeine-form and amount/day: _____

Please indicate what immunizations your child has had:

□DPT (Diphtheria, Pertussis, Tetanus)	□Haemophilus Influenza B	□Hepatitis A
□Tetanus Booster, when? _____	□Influenza (flu)	□Hepatitis B
□MMR (measles, Mumps, Rubella)	□Polio	□Smallpox
□Chicken Pox Tuberculosis	□Other _____	

Please indicate if any caused adverse reactions: _____

Does your child get regular screening tests done by another doctor? (Blood tests etc) □Yes □No

DIET

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: (include quantities)

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages: _____

FAMILY HISTORY

Indicate if a close relative (parent, sibling) has had any of the following:
□Alcoholism □Allergies □Asthma □Cancer □Depression □Diabetes □Epilepsy □Gonorrhea □Hepatitis □Leukemia □Pneumonia □Syphilis □Tuberculosis □Heart Disease □Hypertension □Kidney Disease
□Other: _____ □I don't know my child's medical history

PRENATAL AND NEO NATAL

Were there any maternal health concerns before, during or immediately after pregnancy? If so, please describe:

_____
_____
_____
_____

Age of mother at conception: _____
Age of father at conception: _____
Health of Father at conception: _____
Sibling's age and health status: _____

Prenatal history (mother's health during pregnancy): Please circle and expand when necessary

Thyroid problem	Ultrasound
Gestational diabetes	Other interventions
Nausea	Emotional trauma
Vomiting	Drug Abuse
Toxemia	Alcohol abuse Smoking
Hypertension	Working situation
Anemia	Medication
Genital herpes	Supplements
Bleeding	Known toxic exposure
Other	

Child's Health at Birth:

Full term? □Yes □No	Premature? □Yes □No
Cesarean? □Yes □No	Vaginal Birth □Yes □No
Induced labour? □Yes □No	Other interventions? □Yes □No
Length of labour?	Location of labour?
Weight	Length
APGAR score	Jaundice
Early infection	Anemia
Others	

Were any medications/herbs/remedies used at delivery?

_____

_____

_____

_____

Neonatal health history: (first 2 months)

Any early medical interventions (what, result, reaction)?
Illness: (circle them) Infections Anemia Colic Jaundice Rashes Respiratory Distress Other?
Medication was used, effect and reaction?
How long did the baby stay in the hospital after birth?

Was your child breast-fed? □Yes □No If yes, for how long? _____
Was your child bottle-fed? □Yes □No If yes, for how long? _____
What type of formula? □Yes □No
Was cow's milk used? □Yes □No
Does your child drink cow's milk now? □Yes □No If yes, how much? _____
At which age was food introduced? _____
Which foods were first? _____
Are there family pets? □Yes □No
If yes, please list: _____

Developmental Milestones (give age in months up to 2 years old):

Rolling over		Standing		First teeth		Runs Well	
Holds head up		Crawling		Talking		Catches ball	
Sitting up		Walking		Climb stairs			

Check any of the following the child may have had:

Measles		Asthma		Ear infection		Bedwetting	
Mumps		Whooping cough		Eye problem		Kidney infection	
Rubella		Strep Throat		Hearing problem		Parasites	
Chicken pox		Tonsillitis		Growing pain		Meningitis	
Warts		Pneumonia		Constipation		Allergies	
Eczema		Bronchitis		Diarrhea		Difficult teething	
Cradle cap		Hay Fever		Digestion problem		Anemia	
Diaper rash		Frequent colds		Hernia		Slow growth	
Thrush		Sinusitis		Appendicitis		Sleep Problem	

ENVIRONMENTAL

Hobbies: _____
Does your child exercise regularly? □Yes □No
If yes, what type, how much and how often?

_____

Is your child exposed to significant tobacco smoke? □Yes □No

How is your home heated? _____

Is your child regularly exposed to toxins or other hazards (school, home, hobbies, etc)? Please describe:

_____

How would you describe the emotional climate of your home?

How stressful is school, or other aspects of your child's life? How well does your child handle these stressed? Is your child bullied?

In general, does the child feel hot or cold?

What does the child fear?

How is the child's appetite?

Any food cravings or aversions?

What is the child's mood generally?

What is the child's personality?

Who takes care of the child all day?

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