Naturopathic Child Intake Form

Name _____ **Date of birth** _____

Date _____ **Sex** M F

Who is filling out this form (name and relation)?_____

Contacts (in order of preference)

Name _____ Phone

Address (H) _____

_____ (W)_____

_____ (Other)_____

_____

_____

_____

Relationship to child

_____

Name _____ Phone

Address

_____ (H)_____

_____ (W)_____

_____ (Other)_____

_____

_____

Relationship to child

_____

May we leave messages relating to your visits? Y / N Which Phone Number?_____

With whom does the child live? _____

What are your child's health concerns, 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 or injuries, and any hospitalizations; along with approximate dates:

_____
_____
_____
_____
_____

Which of the following has your child had? Please circle if applicable.

rubella (german measles)	roseola	impetigo
Measles	scarlet fever	Infectious mononucleosis
chicken pox	whooping cough	ear infections
Mumps	strep throat	

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

_____
_____
_____

Please list all current /past medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)
Current-

_____
_____
_____

Past -

_____
_____
_____

How many times has your child been treated with antibiotics in the past ?

_____

Please indicate what immunizations your child has had

☐ DPT (diphtheria, pertussis, tetanus) ☐ Haemophilus influenza B ☐ Hepatitis B

☐ Tetanus booster; when? ☐ "Flu" ☐ Hepatitis A

_____

☐ MMR (measles, mumps, rubella) ☐ Polio

Other _____

Please indicate if any caused adverse reactions

_____

_____

_____

_____

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 the pregnancy?

Poor	Fair	Good	Excellent	Unknown

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

How was the mother's diet during pregnancy?

Poor	Fair	Good	Excellent	Unknown

Did the mother receive prenatal medical care? Y N 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: _____ wks ☐ Late: _____ wks

Length of labor: _____ 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 as well.)
_____
_____
_____
_____

6–12 months?
_____
_____
_____
_____

Did your child ever experience colic? Y N 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 Unknown

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 behavior and performance at school?

_____

_____

Family History

Indicate if a close relative (parent, sibling) has had any of the following

	Who?		Who?
Allergies		Diabetes	
Asthma		Kidney disease	
Birth defects		Other	
Juvenile arthritis			

☐ I don't know the family medical history

Do either of the parents have a chronic illness? Y N Please describe

_____

_____

Environment

Is the child in school , daycare , home care, other_____

What are your child's favorite activities?

_____

_____

Does the child exercise regularly? Y N How much, 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? Y N

Are there animals in the home? Y N

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?

Consent to Treatment of a Minor

Please note that this form must be signed prior to first appointment.

I authorize _____, Doctor of Naturopathic Medicine, who has been engaged by me to examine and administer naturopathic treatment to _____ whose relationship to me is as a _____

I understand:

- The clinic does not guarantee treatment results.
- That the Naturopathic Doctor will explain to me the exact nature of any treatment provided and will answer any questions I may have. I am encouraged to ask questions about assessment and treatment.
- I am free to withdraw my consent and to discontinue treatment at any time.
- I am at liberty to seek or continue medical care from a medical doctor or other licensed health care providers.
- I understand that Naturopathic services are not covered by OHIP. I agree to pay my full account at the time of each visit.
- I understand that a 48 hour cancellation policy is in effect. Full fees are applied without 48-hour notice.
- I understand that advice given via email will be only for clarification of information provided during in patient visits.

My name, address and telephone number, or that of another contact person for the patient (whichever is appropriate) is as follows:

_____

_____

_____

DATED at City, in this Province, _____ day of _____

_____

Parent or Guardian of Minor – Print name Signature

_____

Witness – Print name

Thank you for your time and patience to fill this form.