The Family Naturopathic Clinic: a Naturopathic Teaching Clinic Serving Young Families

Located at Acacia Integrative Health Clinic

Child Intake Form

GENERAL INFORMATION: Date_____ MSP#_____

Blood type_____

Name_____Birthdate_____Phone_____

Address_____City_____Prov/State_____

Postal Code_____ Parent/guardian's name_____ Phone(home)_____

Phone (work)_____ Email _____Best time to call_____

Occupation_____ (full or part-time)

Other parent or guardian_____ Phone (home)_____

Emergency contact_____relation?_____Phone_____

How did you hear about me?_____

Please list below all other health professionals your child is currently seeing (complimentary and conventional) and their contact numbers. Include their area of practice (GP, chiropractor, etc.)

_____

_____

CURRENT HEALTH CONCERNS:

What is your main reason for seeking naturopathic care for your child? If he/she has a specific health condition, please describe it in detail. When was the first time that you noticed the condition and describe any factors that you suspect may have played a role in its onset and its continuation?

_____

_____

How long has this been troubling your child?_____

Has it been getting (better, worse, remaining the same) and for how long?

_____

In order of importance, list other health concerns that are troubling your child:

1.) _____Since when? _____

2.) _____Since when? _____

3.) _____Since when? _____

Other concerns:_____

List all medications, supplements, herbs and homeopathic medicines your child is currently taking. Include dosage and results:_____

_____

List any treatments your child has had for this condition (surgery, acupuncture, massage, etc.) and the results. Include dates:_____

_____

If your child has been treated homeopathically in the past, please list the remedies taken, at what dose (strength & frequency), and with what results:

_____

_____

YOUR CHILD'S HEALTH HISTORY:

Child's general state of health is (Circle): excellent good average fair poor

Prenatal History:

What was the level of health of both parents at time of conception? (circle)

Mother: poor fair good excellent

Father: poor fair good excellent

What was the state of health of the mother during the pregnancy?

Poor Fair Good Excellent

Was this a planned pregnancy? (yes / no) If not, what type of birth control was used?_____

Did the mother have any of the following during pregnancy (circle):

trauma (any kind)	chicken pox	Toxoplasmosis	rubella (Germanmeasles)
Chlamydia	HIV	genital herpes	syphilis
strep infection	severe nausea	Hypertension	diabetes
hypothyroidism	hyperthyroidism	eclampsia	depression

Other:_____

List any supplements, medicines, herbal medicines and homeopathic medicines taken by the mother during pregnancy:_____

_____

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What was the mother's emotional state during pregnancy?:_____

Natal History:

How / where was your child delivered? (circle)

home birth hospital birth vaginal delivery C-section breech head-first

Were there any interventions during the child's birth? (circle)

induction (any type) vacuum extraction forceps epidural pain control

Length of pregnancy in months:_____ Length of labour in hours:_____Birth weight:_____

Mother's age at birth:____ _____APGAR score_____

List any complications not covered above:_____

Neonatal History:

Did your child have any of the following in the first year of his/her life? (circle)

Birth defects	Anemia	Respiratory problems
Jaundice	Rashes	Allergies
Birth injuries	Convulsions	Ear infections
Colic	Lack of appetite	

Other:_____

After the first year:

Childhood Illnesses (circle):

Chicken pox	Measles	Mumps	Impetigo	Diarrhea
Polio	Strep throat	Scarlet fever	Allergies	Eczema
Lice	Pink eye	Tonsillitis	Tuberculosis	Colic
Constipation	Pneumonia	Croup	Diaper rash	Vision loss
Asthma	Cradle cap	Nose bleeds	Hearing loss	Hypothyroidism
Bed wetting	Ear infections	Anemia	Hyperactivity	Chronic infection
Depression	ADD/ADHD	Autism	Cancer	Oral herpes
Crohn's disease	Ulcerative colitis	Hypoglycemia	Epilepsy	Hyperthyroidism
Diabetes	Warts	Heart disease	Heart attack	
Canker sores	Hypertension	Hepatitis	Whooping cough	
Mononucleosis	Diabetes	Rubella	Diphtheria	

Please list the five most significant, stressful events in your child's life, from the most recent to the most distant. Are any of these situations continuing to impact his or her life? (If so place a star next to the event.)

1.) _____ Date_____

2.) _____Date_____

3.) _____Date_____

4.) _____Date_____

Is your child currently working with a professional counsellor, psychologist, social worker, pastor, rabbi, psychiatrist, or other therapist?
(yes / no) Have they in the past? (yes / no) If so, when?_____

Previous surgeries and hospitalizations not mentioned above (include dates)_____

_____

Does your child have any allergies to any drugs, herbs, foods, animals or other? (yes / no)
Please list:_____

NUTRITIONAL HISTORY:

Was your child breast fed? (yes / no) Until what age?_____Any problems?_____

If formula was used, which one was it?_____Any problems?_____

Food Introduction:
Please list foods introduced, in the order of introduction, with age and any reactions you noticed.

Food Introduced	Age	Reaction
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Describe your child's typical daily diet:

_____

What is your child's favourite food?_____Least favourite food?_____

How much water does your child drink a day?_____

Any problems with bowel movements? If so, describe:_____

VACCINATIONS:

Please note next to each vaccination, when the shot was given and any reaction noticed:

MMR_____

DPT_____

Polio_____

Hemophilus influenza B_____

Hepatitis B_____

Chicken pox_____

Other_____

GROWTH AND DEVELOPMENT:
Note age, in months, when your child started to:
Roll over_____Sit up_____Crawl_____Walk_____Talk_____

When did their first tooth start coming in?_____ Any problems?_____

When was bladder control achieved?_____ Bowel control?_____

Has your child had problems with toilet training? (yes / no) Describe:_____

Does your child have any speech problems? (yes / no)_____

Does your child have any of the following habits? (circle)
bed rocking head banging thumb sucking tics breath holding nail biting

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SLEEP:
Does your child have currently and/or in the past: (circle)
nightmares insomnia sleep walking bed wetting teeth grinding

FAMILY HISTORY:
Please list ages, health problems and if deceased, cause of death:

	Living (age)?	Health problems	Died (age)?	Cause
Mother				
Father				
Siblings				
Maternal:				
Grandfather				
Grandmother				
Paternal:				

Grandfather				
Grandmother				

What is your child's ethnicity?_____

Does your child have any blood relative who suffers/or who has suffered from: (circle)

allergies	Arthritis	asthma	cancer	diabetes
depression	Eczema	heart disease	genetic disease	hypertension
ulcers	Cataracts	thyroid disease	hypoglycemia	seizures
gonorrhea	tuberculosis	syphilis	schizophrenia	bipolar disorder
anemia	Stroke	sickle cell	Alzheimer's	

ENVIRONMENT:

Describe your child's current living arrangements:_____

What are your child's main interests and hobbies?_____

What does your child worry about?_____

How often does your child exercise per week?_____ What kind and for how long?_____

Does your child have dietary restrictions; religious or ethical?_____

What religion is your child?_____

Is your child in daycare? (yes / no) How many hours of TV does he/she watch per day?_____

How much time per day does your child spend playing video games or using the computer?_____

To your knowledge, has your child ever been physically or sexually abused?_____

How long has your child lived at his/her present address?_____

Where has she/he lived previously?_____

Is the home damp or moldy? (yes / no) How is your home heated?_____

Is your child exposed to second hand smoke? (yes / no)

What kind of drinking water does your child drink? (circle)
bottled water filtered water distilled water tap water

List any pets in the child's home:_____

Does your child have any problems at school? If so describe:_____

Please feel free to comment on any other concerns in the space below. Thank you for taking the time to fill out this form. The information is extremely useful for developing an effective treatment plan for your child.

_____

_____

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Please return completed form to:

The Family Naturpathic Clinic: a Naturopathic Teaching Clinic Serving Young Families

Suite #101-391 Tyee Road, Dockside Green, Victoria, BC, V8W 2J9
Confidential fax: 250-590-1502
If you have any questions, please call: 250-475-1522