CHILD NATUROPATHIC INTAKE

Name: ________________________ Date of Birth (M/D/Yr)_________________
Address:________________________ Postal Code:____________________________
Who is filling out this form (name and relation)_________________________
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Contacts

Name __________________________ Phone________________________________
Address____
Relationship to child____

Name __________________________ Phone________________________________
Address____
Relationship to child____

With whom does the child live with?_______________________________________
Does your extended health care cover Naturopathic services ? (Y/N)
Has your child had previous Naturopathic services? (Y/N) When:______________
Has your child had previous Chiropractic services ? (Y/N) When:______________
Date of last medical visit: _________________ Reason for visit:_________________
____

Family Physician:____

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

1. ____
2. ____
3. ____
4. ____
5. ____

Prenatal Health

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 the pregnancy ?
Poor Fair Good Excellent 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 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 child fed as an infant?

Breastfed- How long? ____

Formula- Milk / Soy/ Other____

Other____

Please list the first foods introduced to your child with the approximate month.

____

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____

Did your child ever experience colic? ____

Does your child have any dietary restrictions (vegetarian etc.) ?

____

Describe a typical day's diet:
Breakfast ____
Lunch____
Dinner____
Snacks ____
Beverages ____
How often does your child have a bowel movement?___________________________
Does your child have any problems with digestion?___________________________

Past Injuries and traumatic events:
____ When: ____________________

Past surgeries and hospitalizations:
____ When:____________________

Past vaccinations:____

____

Any adverse reactions to the vaccinations?__________________________________

____

Last prescriptions for antibiotics:_________________ reason __________________

____

Please list allergies (if any) : ____

Please list all currently used medications: __________________________________

____

____

____

Please list all currently used supplements: __________________________________

What kind of physical activity does your child do? ___________________________

____

Are there any conditions after which your child had never been totally well again?

____

Family Health History

Indicate below which of the following ailments, or any other ailments, which have affected your child's relatives:

Alcoholism Allergies Alzheimer's Arthritis	Asthma *Cancer Depression Diabetes	Epilepsy Gonorrhea Gout Hay Fever	Heart disease Hypertension Kidney Disease Mental Illness	Paralysis Pneumonia Skin disease Digestive disorders	Syphilis Thyroid Disorders Tuberculosis
RELATIVE		**Age if alive**	**Age at death**	**AILMEMTS**	
Mother					
Father					
Brother					
Sisters					
Maternal Grandmother					
Maternal Grandfather					
Maternal Aunts/Uncles					
Paternal Grandmother					
Paternal Grandfather					
Paternal Aunts/Uncles					

Please specify type of cancer (primary source)______________________________

____

Is your child exposed to or does your child consume any of the following:

- cigarette/ tobacco smoke
- aluminum pans
- candy
- carbonated beverages
- fast foods
- fried foods
- luncheon meats
- margarine
- microwave
- refined sugars
- saccharine (sweet & low)

Do you know of any toxins or hazards to which your child is regularly exposed to ?

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How would you describe the emotional climate of your child's home.

____

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Is there any thing else important that has not been covered?

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