



**CHILD INTAKE FORM**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

(First) (Last)

Date of Birth: \_\_\_\_\_ (Y/M/D) Sex:  F  M

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Appt # : \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Contact Phone Numbers:

Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

May we leave messages relating to your visits?  Y  N

Email Address: \_\_\_\_\_

Emergency Contact:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about Natura Wellness Clinic?

\_\_\_\_\_

If you were referred, please indicate the name of the person who referred you: \_\_\_\_\_

\_\_\_\_\_

Medical/family Doctor: \_\_\_\_\_ Permission to contact them?  Y  N

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Date of last visit? \_\_\_\_\_

Other health care provider you are seeing? \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Permission to contact them?  Y  N

Date of last visit? \_\_\_\_\_

What are your health concerns in order of importance?

1. \_\_\_\_\_ 2. \_\_\_\_\_  
 3. \_\_\_\_\_ 4. \_\_\_\_\_

**Medical History:**

Please indicate any serious condition, illness, injuries, or hospitalization:

1. \_\_\_\_\_ Date: \_\_\_\_\_  
 2. \_\_\_\_\_ Date: \_\_\_\_\_  
 3. \_\_\_\_\_ Date: \_\_\_\_\_  
 4. \_\_\_\_\_ Date: \_\_\_\_\_

Do you have any allergies that you are aware of? (medication, environmental, food, pet, etc.)

1. \_\_\_\_\_ 2. \_\_\_\_\_  
 3. \_\_\_\_\_ 4. \_\_\_\_\_

Please list all medications (prescriptions, over the counter, vitamins, herbs, homeopathics, etc):

| Past Medications | Current Medications |
|------------------|---------------------|
|                  |                     |
|                  |                     |
|                  |                     |
|                  |                     |
|                  |                     |
|                  |                     |
|                  |                     |
|                  |                     |

Immunization record – Please check if applicable:

| ✓ | Vaccination                          | Date | Adverse Effects |
|---|--------------------------------------|------|-----------------|
|   | DPT (diphtheria, pertussis, tetanus) |      |                 |
|   | Haemophilus Influenza B              |      |                 |
|   | Hepatitis A                          |      |                 |
|   | Hepatitis B                          |      |                 |
|   | Influenza (flu shot)                 |      |                 |
|   | Tetanus booster                      |      |                 |
|   | MMR (measles, mumps, rubella)        |      |                 |
|   | Polio                                |      |                 |
|   | Other _____                          |      |                 |

How many times has your child been treated with antibiotics? \_\_\_\_\_

Has your child had any screening tests such as blood, hearing, vision, etc? \_\_\_\_\_

**Family History:**

Has anyone in your family had any of the following conditions, if yes please indicate which family member?

| <b>Condition</b>     | <b>Family Member(s)</b> |
|----------------------|-------------------------|
| Alcoholism           |                         |
| Allergy              |                         |
| Asthma               |                         |
| Autoimmune disorder  |                         |
| Cancer               |                         |
| Depression           |                         |
| Diabetes             |                         |
| Drug Abuse           |                         |
| Heart Disease        |                         |
| High Blood Pressure  |                         |
| Kidney Disease       |                         |
| Other Mental Illness |                         |
| Thyroid Dysfunction  |                         |
| Other _____          |                         |

I don't know my family history

**Prenatal Health:**

What was the health of the parents at conception?

Mother -  Poor  Fair  Good  Excellent  
Father -  Poor  Fair  Good  Excellent

What was the health of the mother during the pregnancy?

Poor  Fair  Good  Excellent

What was the mother's age at child's birth? \_\_\_\_\_

Did mother receive prenatal medical care?  Y  N If yes, what? \_\_\_\_\_

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

Bleeding  Diabetes  High blood pressure  
 Nausea  Vomiting  Physical or emotional trauma  
 Thyroid problem  Other: \_\_\_\_\_

Did the mother use any of the following during pregnancy?

|                             | Yes | No | If yes, indicate what? |
|-----------------------------|-----|----|------------------------|
| Alcohol                     |     |    |                        |
| Tobacco                     |     |    |                        |
| Recreational drugs          |     |    |                        |
| Prescription medication     |     |    |                        |
| Over the counter medication |     |    |                        |
| Supplements                 |     |    |                        |
| Other                       |     |    |                        |

**Birth History:**

Term length:  Full term                       Premature \_\_\_\_ wks                       Late \_\_\_\_ wks  
 Was the birth:  Vaginal                       C-section                       Induced  
                      Forceps                       Anesthesia used

Were there any complications with birth? \_\_\_\_\_  
 \_\_\_\_\_

Did the child experience any of the following?

Rashes                       Jaundice                       Rashes  
 Birth injuries \_\_\_\_\_  
 Birth defects \_\_\_\_\_  
 Other: \_\_\_\_\_

**Diet:**

How was your infant Fed?

Breast Fed. How long? \_\_\_\_\_  
 Formula. Milk/Soy/Other \_\_\_\_\_  
 Other: \_\_\_\_\_

Did your child ever experience colic?  Y     N

Does your child have any dietary restrictions (allergy, religion, vegetarian, vegan, etc.)?  
 \_\_\_\_\_  
 \_\_\_\_\_

Describe a typical day's diet:

Breakfast: \_\_\_\_\_  
 Lunch: \_\_\_\_\_  
 Dinner: \_\_\_\_\_  
 Snacks: \_\_\_\_\_  
 Beverages: \_\_\_\_\_

**Development:**

How was your child's health in the first year of life?

- Poor       Fair       Good       Excellent

At what age did your child do the following:

Sit up \_\_\_\_\_      Crawl \_\_\_\_\_      Walk \_\_\_\_\_      Talk \_\_\_\_\_

How would you describe your child's temperament?

---

---

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

---

---

**Social/Environmental:**

Is your child in:  School       Daycare       Home care       Other: \_\_\_\_\_

Does your child exercise regularly?  Y  N      If yes, what type of exercise and how often per week? \_\_\_\_\_

Are the child's parent:       Married       Separated       Divorced

Does the child have any siblings?  Y  N      How many? \_\_\_\_\_

How is the health of the child's siblings?

- Poor       Fair       Good       Excellent

Is your child exposed to tobacco smoke regularly?  Y  N

Is your child frequently exposed to animals?  Y  N

Is your child frequently exposed to toxins and other hazards?  Y  N

Would you say your child has good energy levels?  Y  N

Would you say your child sleep well?  Y  N

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

---

---