CANADIAN COLLEGE OF NATUROPATHIC MEDICINE

ROBERT SCHAD NATUROPATHIC CLINIC

Child Intake

PLEASE COMPLETE THIS FORM AND RETURN IT TO CLINIC RECEPTION

(Please print clearly)

Child's Name _________________________ Date of birth _______________

Preferred Pronoun: He She Other_____ Today's date: ___________

Who is filling out this form:_______________________Relationship to child: __________________

Contacts in order of preference:

(1) Name _________________________________ Relationship to child: __________________
Address:__________________________________ Apt/unit #____________
City ___________________________ Province _______ Postal Code____________
Telephone number: Home:____________ Work:____________ Cell:________________
E-mail Address:____

(2) Name _________________________________ Relationship to child: __________________
Address:__________________________________ Apt/unit #____________
City ___________________________ Province _______ Postal Code____________
Telephone number: Home:____________ Work:____________ Cell:________________
E-mail Address:____

(3) Name _________________________________ Relationship to child: __________________
Address:__________________________________ Apt/unit #____________
City ___________________________ Province _______ Postal Code____________
Telephone number: Home:____________ Work:____________ Cell:________________
E-mail Address:____

May we leave messages relating to your visits? Which Phone Number__________

With whom does the child live? ____

How did you hear about our Clinic/Who referred you? Please check one of the following:

- ❑ A patient of the clinic (please provide name) _____________________________
- ❑ My medical doctor/Specialist (please provide name) ______________________
- ❑ Other Health Care Provider (please provide name):______________________
- ❑ Advertising (newspaper, TTC, brochure)
- ❑ Social Media (Facebook, Twitter etc.)
- ❑ CCNM Website
- ❑ CCNM Student, staff or faculty
- ❑ Information Session
- ❑ External Sports Medicine event
- ❑ CCNM E-Newsletter
- ❑ Other: ___________________________

Other health care providers the child is seeing:

Name:______________________ Name:______________________ Name:______________________

Specialty:____________________ Specialty:____________________ Specialty:____________________

Ph (__________)_______________ Ph (__________)_______________ Ph (__________)_______________

Date of last visit: ______________ Date of last visit: ______________ Date of last visit: ______________

Have you ever consulted for your child (Please check all that apply):

☐ Naturopathic doctor ☐ Acupuncturist ☐ Nutritionist ☐ Counselor

Health Goals

What are your health concerns and goals, in order of importance:

Please list most important health concerns and goals in their order of significance:	Prior diagnosis of this problem? If so, what?
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.

1) ____________________________ 4) ____________________________
2) ____________________________ 5) ____________________________
3) ____________________________ 6) ____________________________

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

1) ____________________________ 4) ____________________________
2) ____________________________ 5) ____________________________
3) ____________________________ 6) ____________________________

Please list all current medications/natural health products (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

1) _______________ 3) _______________ 5) _______________
2) _______________ 4) _______________ 6) _______________

Please list past prescription medications/natural health products:

____

____

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

Which of the following has your child had? (**N**-never, **M**-mild, **A**-average, **S**-severe)

Rubella (german measles)	Roseola	Impetigo
Measles	Scarlet Fever	Mononucleosis
Chicken pox	Whooping Cough	Ear Infections
Mumps	Strep Throat	

What screening tests has your child had (blood, hearing, vision, etc.)____

____

Please indicate what immunizations your child has had:

☐ DPT (diphtheria, pertussis, tetanus)	☐ Haemophilus influenza B	☐ Hepatitis A
☐ Tetanus booster; when? ______________	☐ "Flu"	☐ Hepatitis B
☐ MMR (measles, mumps, rubella)	☐ Polio	☐ Pneumococcal conjugate
☐ Rotavirus	☐ Chicken pox	☐ Meningococcal Conjugate
☐ HPV/Gardasil		

Other ____

Please indicate if any caused adverse reactions:____

Prenatal health

What was the age of the mother at child's birth? _________ What was the age of the father at child's birth? _________

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 pregnancy?	Poor	Fair	Good	Excellent	Unknown
How was the mother's diet during pregnancy?	Poor	Fair	Good	Excellent	Unknown
Did the mother receive prenatal care?	Y	N	Unknown		

Did the Mother experience any of the following during pregnancy:

☐ Bleeding	☐ High Blood Pressure	☐ Nausea	☐ Vomiting
☐ Diabetes	☐ Thyroid Problems	☐ Physical or emotional trauma	

Did the mother use any of the following during 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 ____________________ Length 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? Breastfed, how long? __________ Formula_______ Milk/Soy/other: ______________

What foods were introduced: Before 6 months?
(please list approximate month as well)

____
____
____

6-12 Months?

____
____
____

Did your child ever experience colic? Yes No 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 ______________ First tooth______________

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?

____

____

Personal and Family History

Please indicate "Y" in the "Yes" box next to each condition that applies to you and/or one of your family members. Please indicate who who the condition applies to: "**Child**" if it relates to your child and/or Father (**F**), mother (**M**), sibling (**S**), Grandparent (**G**). Please indicate **Past** if the condition is resolved, or **Current** if it is on-going and current

	Yes	Relation Child F M S G	Past or Current		Yes	Relation Child F M S G	Past or Current
Alcoholism/Drug addiction				High Blood pressure			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				Headaches			
Asthma				Kidney disease			
Cancer				Stroke			
Diabetes				Tuberculosis			
Eczema				Osteoporosis			
Epilepsy				Others:			
Depression/other Mental Illness							

- ❑ I don't know the family medical history

Do either of parents have chronic illness Y N Please describe: ________________________________

____

Environment

Is the child in: School daycare homecare other

What are your child's favourite activities ?____

____

_

Does your child exercise regularly? What do they do for exercise, how much, how often?

____

____

How much:

Television does your child watch? ______________________ hours a day/week

Computer time does your child have? ______________________ hours a day/week

Video game time does your child play? ______________________ hours a day/week

Tablet time does your child have ______________________hours a day/week

Cell phone time does your child have? ______________________ hours 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? Natural Gas Oil Electric Wood Other: ___________

Do you know of any toxin or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)?
Please describe:

Is the child regularly or has ever been regularly exposed to solvents, heavy metals, fumes pesticides/herbicides or other toxic materials? Please describe:

Is your child particularly sensitive to perfumes, gasoline or other vapours (such as from new furniture, carpets, paints etc.)?

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

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