211-3885 Duke of York Blvd., Mississauga ON L5B 0E4 T:(905)276-6800 F:(905)276-6802

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? ____________________

____

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Family History:

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

Condition	Family Member(s)
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: ____

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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: ____

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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?

____

____

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