

**TARA CLAPP, B.Sc., ND, ERIN RISEING B.Sc., N.D.**

577 Ontario Street St. Catharines, ON L2N 4N4.

•Tel: (905) 988-9160 Fax (905) 988-9147

**INTAKE FORM FOR CHILDREN**

CHILD'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

CHILD'S ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ Postal Code \_\_\_\_\_

PARENTS NAMES \_\_\_\_\_

Parent's Cell# \_\_\_\_\_ Parent's E-mail \_\_\_\_\_

CAREGIVER'S NAMES(S) (if appropriate)

\_\_\_\_\_

PHONE NUMBER: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Other) \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_

FAMILY PHYSICIAN/PEDIATRICIAN \_\_\_\_\_

PHONE \_\_\_\_\_ HEALTH CARD # \_\_\_\_\_

**SIBLINGS (Names and Ages)**

\_\_\_\_\_

How did you find out about our office?

\_\_\_\_\_

If you have insurance coverage, please list name of insurer:

\_\_\_\_\_

What treatments have been tried (please include both conventional and complementary)?

\_\_\_\_\_

—

\_\_\_\_\_

—

Please list any concerns that you have about your child's health:

1. \_\_\_\_\_ length of time \_\_\_\_\_

2. \_\_\_\_\_ length of time \_\_\_\_\_

3. \_\_\_\_\_ length of time \_\_\_\_\_

4. \_\_\_\_\_ length of time \_\_\_\_\_

Please list any medications (including over-the-counter) that your child has taken:

**Presently**

**In the past**

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY**

What was the age of the parents at the time of conception? **Mom:** \_\_\_\_\_ **Dad:** \_\_\_\_\_

What was their general state of health at that time?

Mom: **Excellent** \_\_\_\_\_ **Good** \_\_\_\_\_ **Average** \_\_\_\_\_ **Fair** \_\_\_\_\_ **Poor** \_\_\_\_\_  
 Dad: **Excellent** \_\_\_\_\_ **Good** \_\_\_\_\_ **Average** \_\_\_\_\_ **Fair** \_\_\_\_\_ **Poor** \_\_\_\_\_

Please indicate which of the following conditions apply to your immediate family:

<b>Allergies</b>		<b>Arthritis</b>		<b>Asthma</b>		<b>Auto-immune disease</b>	
<b>Birth defects</b>		<b>Bleeding disorders</b>		<b>Cancer</b>		<b>Deafness</b>	
<b>Depression</b>		<b>Diabetes</b>		<b>Eczema</b>		<b>Heart disease</b>	
<b>Hepatitis</b>		<b>Herpes</b>		<b>HIV/AIDS</b>		<b>Hypertension</b>	
<b>Kidney disease</b>		<b>Mental illness</b>		<b>Peptic ulcer</b>		<b>Thyroid disease</b>	
<b>Tuberculosis</b>		<b>Visual problems</b>		<b>Speech problems</b>		<b>Frequent infections</b>	

Other: \_\_\_\_\_

**PRENATAL HISTORY**

Please indicate if any of the following conditions were experienced by mom during pregnancy:

<b>Diabetes</b>		<b>Edema (swelling)</b>		<b>Emotional trauma</b>		<b>Depression</b>	
<b>Fainting</b>		<b>German measles</b>		<b>Herpes</b>		<b>Infections</b>	
<b>Nausea</b>		<b>Physical trauma</b>		<b>Pregnancy induced hypertension</b>		<b>Thyroid problems</b>	
<b>Toxemia</b>		<b>Vomiting</b>		<b>Excessive weight gain</b>		<b>Weight loss</b>	

Please list any medications taken during pregnancy (including over-the-counter):

\_\_\_\_\_

\_\_\_\_\_

Did mother use any of the following during pregnancy? Please indicate how much and for how long.

<b>Alcohol</b>		<b>Tobacco</b>	
<b>Hormones</b>		<b>Coffee</b>	
<b>Cortisone</b>		<b>Laxatives</b>	
<b>Sedatives</b>		<b>Antacids</b>	
<b>Recreational drugs</b>		<b>Aspirin or Tylenol</b>	

Please list any supplements/herbs taken during pregnancy:

---

—

---

—

How would you describe the pregnancy?

---

### **BIRTH HISTORY**

Length of gestation: \_\_\_\_\_ Length of labour: \_\_\_\_\_

Was labour spontaneous? **Yes/No** If no, how was it induced? \_\_\_\_\_

Type of delivery: **Vaginal** \_\_\_\_\_ **C-section** \_\_\_\_\_

Location of delivery: **Home** \_\_\_\_\_ **Hospital** \_\_\_\_\_ **Birthing center** \_\_\_\_\_ **Other:** \_\_\_\_\_

Were there any interventions used at birth? **Anesthesia** \_\_\_\_\_ **Epidural** \_\_\_\_\_  
**Episiotomy** \_\_\_\_\_ **Forceps** \_\_\_\_\_ **Vacuum** \_\_\_\_\_ **Other:** \_\_\_\_\_

At birth, what was the child's: **Apgar Score** \_\_\_\_\_ **Weight** \_\_\_\_\_ **Length** \_\_\_\_\_

Please indicate if any of the following conditions were experienced by your child at or soon after birth:

<b>Allergic reaction</b>		<b>Failure to thrive</b>		<b>Respiratory distress</b>		<b>Billi-lights</b>	
<b>Birth defects</b>		<b>Hypoxia</b>		<b>Seizures</b>		<b>Respirator</b>	
<b>Colic</b>		<b>Jaundice</b>		<b>Unusual weight gain</b>		<b>Surgery</b>	
<b>Difficulty feeding</b>		<b>Meningitis</b>		<b>Weight loss</b>		<b>Incubation</b>	
<b>Fevers</b>		<b>Rashes</b>		<b>Meconium (in the lungs)</b>		<b>Drug administration</b>	

## CHILD'S HEALTH HISTORY

Does your child sleep through the night? **Yes/No**

Hours of sleep nightly: \_\_\_\_\_

Does your child nap during the day? **Yes/No**

Does your child experience nightmares? **Yes/No**

Does your child have any known allergies? \_\_\_\_\_

Has your child ever been hospitalized (please list reason and dates)?

\_\_\_\_\_  
 \_\_\_\_\_

Which of the following conditions apply to your child? Please indicate if **now (N)** or in the **past (P)**.

	N	P		N	P		N	P		N	P
<b>Allergies</b>			<b>Diarrhea</b>			<b>Hair loss</b>			<b>Rheumatic fever</b>		
<b>Asthma</b>			<b>Ear infections</b>			<b>Hearing problems</b>			<b>Rubella</b>		
<b>Bed wetting</b>			<b>Easy bleeding</b>			<b>Lice</b>			<b>Scarlet fever</b>		
<b>Bladder infections</b>			<b>Easy bruising</b>			<b>Measles</b>			<b>Seizures</b>		
<b>Bloody urine</b>			<b>Eczema</b>			<b>Meningitis</b>			<b>Sleeping problems</b>		
<b>Body/breath odour</b>			<b>Emotional trauma</b>			<b>Mood changes</b>			<b>Sore throat</b>		
<b>Bronchitis</b>			<b>Eye infections</b>			<b>Mumps</b>			<b>Stomach flu</b>		
<b>Burning urine</b>			<b>Fatigue</b>			<b>Nausea</b>			<b>Strep throat</b>		
<b>Chicken pox</b>			<b>Fever</b>			<b>Nervousness</b>			<b>Tonsillitis</b>		
<b>Frequent colds</b>			<b>Fractures</b>			<b>Night sweats</b>			<b>Unusual fears</b>		
<b>Cough</b>			<b>Frequent urination</b>			<b>Nose bleeds</b>			<b>Vision problems</b>		
<b>Constipation</b>			<b>Fungal infections</b>			<b>Pneumonia</b>			<b>Vomiting</b>		
<b>Croup</b>			<b>Gas</b>			<b>Physical trauma</b>			<b>Bone pain</b>		
<b>Cradle cap</b>			<b>Growing pains</b>			<b>Rash</b>			<b>Whooping cough</b>		

## IMMUNIZATION HISTORY

Has your child ever traveled outside of Canada? **Yes/No** If yes, where? \_\_\_\_\_

Please indicate approximate dates of immunizations where possible and relevant:

**Measles, Mumps, Rubella** \_\_\_\_\_ **Polio** \_\_\_\_\_  
**Small Pox** \_\_\_\_\_ **Influenza** \_\_\_\_\_ **Chicken Pox** \_\_\_\_\_  
**Hepatitis** \_\_\_\_\_ **Diphtheria, Pertussis, Tetanus (DPT)** \_\_\_\_\_

Did your child experience any adverse or odd reactions to the immunizations? **Yes/No**

## **NUTRITIONAL HISTORY**

Was your child breastfed? **Yes/No**                      If yes, for how long? \_\_\_\_\_

If your child was not breast fed, please indicate what food was used. If possible, include the brand.

---

What was the first liquid introduced to your child after this (excluding water)?

---

Please make a brief list of solid foods given in the rough order of introduction.

<u><b>Food</b></u>	<u><b>Age of Introduction</b></u>	<u><b>Adverse Reaction</b></u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

How would you describe your child's eating habits?

---

---

Please provide a rough outline of your child's daily diet:

<b>Breakfast</b>	
<b>Lunch</b>	
<b>Dinner</b>	
<b>Snacks</b>	
<b>Water intake</b>	
<b>Other fluids</b>	
<b>Nutritional supplements</b>	

## **SOCIAL HISTORY**

How would you describe your child's temperament?

---

---

---

How does your child interact with others (adults and other children)?

---

---

---

How does your child handle stressful situations?

---

---

---

How does your child express his/her emotions?

---

---

---

How would you describe your child's performance at school/daycare?

---

---

---

How do you think others would describe your child?

---

---

---

Does your child take part in any extracurricular activities?

---

---

---

### **HOME ENVIRONMENT**

How many people live in your home? \_\_\_\_\_

Are there any smokers in your home? **Yes/No**

Do you have any pets? \_\_\_\_\_

How old is your home (approximately)? \_\_\_\_\_

How is your home heated?

---

In general, how would you describe the emotional climate in this child's household? \_\_\_\_\_

---

---

---

Is there anything else that you would like to tell me about your child?

---

---

---

---

---

How did you hear about our clinic?

---

**Thank you for taking the time to fill out this lengthy questionnaire! It will be a valuable resource in helping to understand your child's health. I look forward to meeting with you in the near future.**