

Dr. Caroline Harvey-Smith, PhD, N.D. *Doctor of Naturopathic Medicine*
The Guelph Naturopathic Healthcare Clinic

INTAKE FORM FOR CHILDREN

Child's Name _____ Sex _____ Age _____

Child's date of birth (dd/mm/yy) _____

Child's Address _____ City _____ PC _____

Caregiver's Name(s) _____

Address if different from above: _____

Phone: Home: _____

Emergency contact: _____

Siblings (name and ages) _____

Family Doctor/Pediatrician

Phone _____ Address: _____

What are your major concerns about your child's health? _____

Are there any other concerns about your child's health? _____

Have any of the above conditions been diagnosed? Y N

If so, by whom? _____

MEDICAL HISTORY

How would you describe your child's general state of health? Good Fair Poor

Which of the following has your child had? (n-never, m-mild, a-average, s-severe) please circle:

n m a s rubella (german measles)	n m a s roseola	n m a s impetigo
n m a s measles	n m a s scarlet fever	n m a s mononucleosis
n m a s chickenpox	n m a s strep throat	n m a s ear infections
n m a s mumps	n m a s whooping cough	

Please list any medications (including over-the-counter, vitamins, homeopathics, herbs etc):

Taken in the past: _____

Presently: _____

Please indicate what immunizations your child has had:

<input type="checkbox"/> DPT (diphtheria, pertussis, tetanus)	<input type="checkbox"/> Tetanus booster, when? _____
<input type="checkbox"/> MMR (measles, mumps, rubella)	<input type="checkbox"/> Haemophilus influenza B
<input type="checkbox"/> "flu"	<input type="checkbox"/> Hepatitis A
<input type="checkbox"/> Polio	
<input type="checkbox"/> Other	

Please indicate if any caused adverse reactions _____

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

When and for what reason? _____

PRENATAL HEALTH

What was the state of the Mother during pregnancy? Poor Fair Good Excellent Unknown

What was the mother's age at child's birth? _____

How was the mother's diet during pregnancy? Poor Fair Good Excellent Unknown

Did the Mother receive prenatal medical care? Y N Unknown

Did the mother experience any of the following during pregnancy?

<input type="checkbox"/> bleeding	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> nausea	<input type="checkbox"/> vomiting
<input type="checkbox"/> diabetes	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Physical or emotional trauma	

Other? _____

Did the Mother use any of the following during the pregnancy? (Please give details)

- Tobacco _____
- Alcohol _____
- Recreational drugs _____
- Prescription drugs _____
- Over-the-counter medication _____
- 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 • Anaesthesia used

Did the child experience any of the following symptoms after birth?

- Jaundice • Rashes • Seizures • Birth injuries _____
- Birth defects _____
- Other? _____

DIET

How was your infant fed?

- Breast fed. How long? _____ • Formula. Milk/Soy/ Other: _____
- Other _____

What foods were introduced before 6 months (please list approximate months as well):

6-12 months?

Did your child ever experience colic? Y N **How severe?** mild moderate severe

Does your child have any food allergies or intolerances? Please list.

Do either of the parents have a chronic illness? Y N Please describe:

DIET

Does your child have any dietary restrictions (religious, vegetarian/vegan etc.)?

Describe a typical diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages (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 _____

Describe your child's sleep pattern

How would you describe your child's temperament? _____

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

FAMILY HISTORY

Indicate if a close relative (parent, sibling) has had any of the following

	Who?		Who?
Allergies		Diabetes	
Asthma		Kidney disease	
Birth defects		Juvenile arthritis	

I don't know the family medical history

ENVIRONMENT

Is your child in: school (grade ? _____) daycare homecare other _____

What are your child's favourite activities?

Does your child exercise regularly? Y N How much, how often? _____

How much television does your child watch? _____ hrs 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 Type: _____

How is your child's home heated? _____

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

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

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

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DECLARATION AND CONSENT TO TREATMENT OF A CHILD

Child's name: _____ Date: _____
(First) (Middle) (Last)

I, _____, hereby give my consent for Dr. Caroline
Harvey-Smith Ph.D., ND. Doctor of Naturopathic Medicine to treat my child or ward.

I take responsibility for all fees incurred.

Signature _____ Date _____

Relationship to child: _____

Witness's signature: _____ Date: _____