Marda Loop Naturopathic and Wellness Clinic

Dr. Hillary, ND www.mardaloopwellness.com

CHILDREN'S INTAKE FORM

Thank you for taking the time to complete the following new patient forms. If you're child is able, it can be fun to do this together! As this form is extensive, it plays an integral role in achieving our mutual goal of your optimal health.

Name			Date
Birth Date d d / m m / y y y y	Age	Gender	Home #
Address			
City	Province		Postal Code
Parent Name		Parent Name	
Parent Phone number		Parent Phone number:	
Primary Contact Parent			
Primary contact email			
Family Doctor – Name and Contact		Other Health Care Practitioners – Name and Contact	
How did you hear about Dr. Hillary?			

Has your child seen a naturopathic doctor previously? _____

Please state your child's reasons for attending this appointment (in descending order of importance):

_____

_____

_____

_____

_____

What expectations do you have for your child's visit to the clinic?

Please list past health problems with dates

Has your child experienced any trauma? Please describe.

Fractures? YES NO Accidents? YES NO Emotional? YES NO

Has your child ever been hospitalized? YES NO If so, please indicate when and why.

Please list any medications and supplements your child is currently taking.

Please list past medications and supplements your child has taken.

How many times has your child taken antibiotics? _____

Has your child had any specialized screening tests (i.e. vision or hearing)? Please explain. _____

Is your child sensitive or have allergies to any of the following (please specify):

Medications: _____

Foods: _____

Environment: _____

Childhood Illnesses: Please circle all that apply (past and present):

Chicken Pox	Fifth's Disease	Polio	Pneumonia	Rubella
Scarlett fever	Hand, foot & Mouth	Measles	Rheumatic fever	Mumps
Mononucleosis	Whooping Cough	Tonsillitis	Frequent Colds	Asthma
Roseola	Colic	Heart murmur	Liver dz/Jaundice	Acne
Cradle cap	Eczema	Bed wetting	Hyperactivity	Croup
Strep Throat	Ear infections	Impetigo	Kidney disease	Other

Vaccinations received (please check or give dates):

Diphtheria, Pertussis, Tetanus	_____	Measles, Mumps, Rubella	_____
Chicken Pox	_____	Pneumonia	_____
Haemophilus Influenza B	_____	Polio	_____
Influenza (flu shot)	_____	Hepatitis B	_____
Rotavirus	_____	Meningitis	_____
HPV	_____		

Any adverse reactions to vaccinations? (redness at site, crying, fever, etc) YES NO If yes, explain:

_____

_____

_____

Has your child travelled outside Canada? YES NO Please list when and where.

_____

_____

Family History

Please list all family members the child lives with: _____

_____

Please indicate, where applicable, if anyone in the child's family currently (C) or in the past (P) has had any of the following conditions:

	Father	Mother	Brothers	Sisters	Maternal		Paternal	
					G.Mother	G.Father	G.Mother	G.Father
Age (if living)								
Health (G=good, P=poor)								
Anemia								
Asthma, Hay fever, Hives								
Cancer								
Cystic Fibrosis								
Diabetes								
Epilepsy								
Rheumatoid Arthritis								
Osteoarthritis								
Heart Disease								
High Blood Pressure								
Kidney Disease								
Mental Illness								
Alcoholism								
Stroke								
Tuberculosis								
Other								
Cause of Death								
Age (at death)								

Prenatal History

Was this child conceived naturally? YES NO

If no, please explain fertility interventions: _____

_____

Any illnesses or difficulties during pregnancy? Circle all that apply.

Bleeding	High Blood Pressure	Physical Trauma	Diabetes
Illness	Thyroid Problems	Emotional Stress	Nausea
Vomiting	Bleeding	Drugs/Alcohol/Smoking	Other: _____

List any supplements or medications taken during pregnancy.

_____

_____

_____

Mothers age at birth: _____

Birth History

How long was the pregnancy? FULL TERM LATE PREMATURE # of weeks: _____

Was the labor SPONTANEOUS INDUCED Duration of labor (hrs): _____
Was there any difficulties or complications? _____

_____

What type of delivery? C-Section Vaginal Hospital Home Birth

Were any interventions used? Epidural Episiotomy Forceps Suction

Was mom Strep B positive? YES NO

Were antibiotics given during birth? YES NO

Baby's Birth Weight: _____ Length: _____ APGAR scores: 1 min _____ 5 min _____

Neonatal History

Any difficulties or complications soon after birth? Circle all that apply.

Anemia Convulsions Poor feeding Birth Defects

Infections Rashes Jaundice Colic

Nutrition

Breast fed? YES NO How long? _____

Approximate feeding schedule: _____

Formula fed? YES NO How long? _____ Formula type? _____

Response to formula, if adverse? _____

Age solid foods began? _____

How many meals does your child generally eat each day? 1 / 2 / 3 / More than 3

List the primary food included in your child's diet?

_____

_____

_____

Are there any food groups excluded from your child's diet? Why?

_____

_____

Are there any foods your child craves? _____

Is your child thirsty? YES NO Amount of liquid child drinks each day? _____ Plain water? _____

What temperature liquids does your child prefer to drink? Hot / Cold / Room Temperature

Sleep Patterns

Does your child have trouble falling asleep? YES NO

Does your child sleep through the night? YES NO

Does your child wake up looking and acting refreshed? YES NO

Does your child have recurring dreams or nightmares? YES NO If yes, what is the theme:

_____

Home Environment

Do you live close to any of the following? Circle any that apply.

Airport Dump Highway Industry Power lines

Have you done any major recent renovations ro your home? YES NO If yes, explain:

_____

How old is your home? _____ How long have you lived there? _____

Do you have any household pets? _____

Is your child exposed to tobacco smoke? YES NO

Child Development and Behavior

Age began: Sitting _____ Crawling _____ Walking _____

Talking _____ First Tooth _____

Any problems with child's teeth? YES NO

If yes, what was the issue and when? _____

How would you characterize your child's development?

Physically: Slow Average Fast Mentally: Slow Average Fast

Has your child started puberty? YES NO

If yes, at what age? _____

How is your child's behavior, attitude and performance at school? _____

How is your child's behavior, attitude and performance at home? _____

How many hours per day does your child use: TV ____ Computer ____ Video Games ____

Write a brief description of your child as he/she currently is. Include a short description of their social interactions with family, friends, their strengths, weaknesses, major personality characteristics:

_____

_____

General Symptoms

How would you rate your child's general state of health? Excellent Good Average Poor

Rate your child's energy level: Low 1 2 3 4 5 6 7 8 9 10 High

Rate your child's stress level: Low 1 2 3 4 5 6 7 8 9 10 High

For the following, place a **check mark** in the space if your child currently has the symptom or a **P** if it has been a problem in the past

SKIN, HAIR & NAILS

_____ acne
_____ changes in skin odor
_____ changes in hair / nails
_____ cradle cap
_____ eczema, rashes
_____ hives, itching

EYES, EARS, NOSE & THROAT

_____ Sore throat
_____ Coughing
_____ Lumps / swollen glands
_____ Discharge (eyes, ears, nose, etc)
_____ Vision problems
_____ Hearing problems
_____ Nose bleeds
_____ Wheezing or difficulty breathing

MUSCLES & SKELETON

_____ Change in posture / gait
_____ Joint pain or stiffness
_____ Muscle pain or stiffness

MENTAL & EMOTIONAL

_____ Cries easily or weepy
_____ Anxiety
_____ Mood Swings
_____ Nervous
_____ Nightmares or night terrors
_____ Strong fears or aversions
_____ Prefers to be alone/with company

DIGESTION & ELIMINATION

_____ Change in appetite
_____ Excessive / diminished thirst
_____ Excessive / diminished hunger
_____ Trouble chewing / swallowing
_____ Frequent vomiting
_____ Stomach / abdominal aches
_____ Excessive belching
_____ Excessive gas
_____ # bowel movements daily
_____ Constipation
_____ Diarrhea
_____ Age at potty training
_____ Fully potty trained?
_____ Bed wetting
_____ Blood in urine
_____ Burning urination
_____ Frequent urination

GENERAL

_____ Heat / cold intolerance
_____ Excessive sweating
_____ Night sweats
_____ High fevers
_____ Motion sickness
_____ Anemia
_____ Easy bruising
_____ Slow wound healing
_____ Body or breath odor
_____ Recent weight change
_____ Weakness or fatigue