Marda Loop Naturopathic and Wellness Clinic

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CHILD NATUROPATHIC INTAKE FORM

This is a comprehensive and confidential intake form that greatly assists in the understanding of your child's physical, mental, and emotional health both past and present. This information is necessary to properly assess you as an individual and prepare an optimal treatment plan. If your child is able, it can be fun to do this together! Thank-you for taking the time to fill out this intake.

Registration Information

Name: _____ Today's Date: _____
(First) (Middle) (Last) dd / mm / yy

Date of Birth: ____/____/____ Age: _____ Gender: _____
dd / mm / yy

Home Address: _____

Town/ City: _____ Province:_____ Postal Code: _____

Guardian Information

Parent Name: _____ Parent phone number: _____
Parent Name: _____ Parent phone number: _____
Primary contact parent: _____
Primary contact email: _____

May we leave messages on your home phone relating to your child's visits? □ Yes □ No

Would you like to receive e-mail reminders about your child's appointments? □ Yes □ No

How did you find out about our Naturopathic Services?
□ Referral - Whom may we thank? _____
□ Newspaper/ magazine / flyer
□ Internet search
□ Other _____

Family Physician: _____ Phone:( )_____

Date of last physical exam or blood work: _____

Other Health Care providers: _____
_____
_____
_____

Has your child seen a naturopathic doctor previously? □ Yes □ No
_____

Chief Health Concerns

What are your child's main health concerns, in order of importance:
1. _____
2. _____
3. _____
4. _____
5. _____

List any other concerns you may want to discuss:
_____
_____
_____

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

Medical History

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

Current weight: _____lbs Height: _____

Please list any past health conditions 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 yes, please indicate when and why.

_____

_____

Please list all current medications and supplements (prescription, over-the-counter, vitamins, herbs, homeopathics), with dosage:

_____

_____

_____

Approximately how many times has your child been treated with antibiotics?

_____

Have your child tried other conventional or complimentary treatments? If so, what were they and what were the results?

_____

_____

_____

Has your child had any specialized screening tests (ie. vision or hearing)? If yes, please explain

_____

_____

Is your child up to date with their vaccinations? □ Yes □ No

_____

_____

Any adverse reactions to vaccinations? (redness at site, fever, etc) □ Yes □ No
If yes, please explain:

_____

_____

Has your child had any of the following childhood illnesses (past or present)?

□ Chicken pox
□ Scarlett fever
□ Mononucleosis
□ Roseola
□ Cradle cap
□ Strep throat
□ Fifth's disease
□ Hand, foot and mouth
□ Whooping cough
□ Colic
□ Eczema
□ Ear infections
□ Polio
□ Measles
□ Tonsillitis
□ Heart murmur
□ Bed wetting
□ Impetigo
□ Pneumonia
□ Rheumatic fever
□ Frequent colds
□ Liver disease/ jaundice
□ Hyperactivity
□ Kidney disease
□ Rubella
□ Asthma
□ Mumps
□ Acne
□ Croup
□ Other: _____

Check any of the following symptoms off that your child is currently experiencing or has experienced in the past

Skin, Hair and Nails
- ☐ Acne
- ☐ Changes in skin odour
- ☐ Changes in hair / nails
- ☐ Cradle cap
- ☐ Eczema, rashes
- ☐ Hives, itching

Digestion and Elimination
- ☐ Change in appetite
- ☐ Excessive / diminished thirst
- ☐ Excessive / diminished hunger
- ☐ Trouble chewing / swallowing
- ☐ Frequent vomiting
- ☐ Stomach / abdominal aches
- ☐ Excessive belching
- ☐ Excessive gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bed wetting
- ☐ Blood in urine
- ☐ Burning urination
- ☐ Frequent urination

bowel movements daily _____
Age at potty training _____
Fully potty trained? ☐ Yes ☐ No

Muscles and Skeleton
- ☐ Change in posture / gait
- ☐ Joint pain or stiffness
- ☐ Muscle pain or stiffness

Eyes, Ears, Nose and Throat
- ☐ Sore throat
- ☐ Coughing
- ☐ Lumps / swollen glands
- ☐ Discharge (eyes, ears, nose, etc)
- ☐ Vision problems
- ☐ Hearing problems
- ☐ Nose bleeds
- ☐ Wheezing or difficulty breathing

Mental and Emotional
- ☐ Cries easily or weepy
- ☐ Anxiety
- ☐ Mood Swings
- ☐ Nervous
- ☐ Nightmares or night terrors
- ☐ Strong fears or aversions
- ☐ Prefers to be alone/with company

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

Allergies

Is your child sensitive or have allergies to any of the following?

Medications: _____
Foods: _____
Environment: _____

What happens when your child has an allergy attack? _____

_____

_____

Family Health History

Please list all the family members the child lives with: _____

_____

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

- ☐ Anemia
- ☐ Asthma, hay fever, hives
- ☐ Cancer (type_____)
- ☐ Cystic fibrosis
- ☐ Diabetes
- ☐ Eczema
- ☐ Epilepsy
- ☐ Rheumatoid arthritis
- ☐ Mental Illness
- ☐ Osteoarthritis
- ☐ Heart disease
- ☐ Kidney disease
- ☐ High blood pressure
- ☐ Alcoholism
- ☐ Stroke
- ☐ Tuberculosis
- ☐ PMS
- ☐ Endometriosis
- ☐ Other _____ _____

Any other medical conditions that run in your family?

_____

_____

_____

Prenatal History

Was this child conceived with fertility interventions? ☐ Yes ☐ No

If yes, please explain? _____

_____

_____

Any illnesses or difficulties during pregnancy?

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

List any supplements or medications taken during pregnancy

_____

_____

Mothers age at birth: _____

How long was the pregnancy? ☐ Full term ☐ Late ☐ Premature # of weeks: _____

Was the labour: ☐ Spontaneous ☐ Induced Duration of labour (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?

□ Anemia □ Birth Defects □ Jaundice
□ Convulsions □ Infections □ Colic
□ Poor feeding □ Rashes

Nutrition

Breast fed? □ Yes □ No For 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?

_____

_____

Favorite foods? _____

_____

Is your child thirsty? □ Yes □ No Amount of liquid child drinks each day? _____

What does your child drink?
Plain water? □ Yes □ No Juice? □ Yes □ No Pop? □ Yes □ No Milk? □ Yes □ No

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?
□ Airport □ Dump □ Highway □ Industry Power lines

Have you done any major recent renovations to your home? □ Yes □ No If yes, explain:

_____

_____

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

Do you have any household pets? □ Yes □ No If yes, what type of 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 _____

Rate your energy level:
□ Excellent □ Good □ Average □ Fair □ Poor

Rate your stress level:
□ Excellent □ Good □ Average □ Fair □ Poor

Is your family or child active in a religion? If so, which religion and how important is this to your life?

_____

_____

_____

Is there anything that you feel that is important that hasn't been covered?

_____

_____

_____

Thank-you for taking the time to complete this intake form! The answers you provide allow me to have a better understanding of who your child is and what the main goals and health concerns are. Please fax, mail, or scan to email this form to the **Marda Loop Naturopathic and Wellness Clinic at least 48 hours before your child's appointment** to ensure I have time to go over what you have written. If sending a copy via e-mail use the addresses are as follows:
patientcare@mardaloopwellness.com.