ROOTED

naturopathic clinic + iv lounge

NATUROPATHIC CHILD INTAKE FORM – Ages 6-11

Child's name: _____

Gender: _____ Date of birth: _____ Age: _____

Parents are (circle one): Married Separated Divorced Common law
Other: _____

Parent's Names & Contact Information

1. _____ Phone Number: _____

Address: _____

2. _____ Phone Number: _____

Address: _____

What number may we leave messages at? _____
Email address_____
Would you like to be included in our monthly e-mail list? ❑Yes ❑No
Emergency contact: _____ Phone: _____
Has any other family member already been a client of this clinic? If so, who:
_____

How did you find out about us? (please check all that apply):
❑Yellow Pages ❑Friend: Whom should we thank? _____
❑Website ❑Professional Referral: Whom should we thank? _____
❑OAND ❑Facebook ❑Other _____

Have you seen an ND before? _____ Who? _____ When? _____

Reason for office visit	How long has this been going on?
1.	
2.	
3.	

Health Care Providers:
Family Doctor: Name: _____ Phone number: _____
Other Providers: Name: _____ Phone number: _____
Name: _____ Phone number: _____

List any surgeries or major illnesses (with dates):

List any current medications and/or supplements (*please bring with you to first appointment):

List any past medications and/or supplements (include dates):

If your child has taken antibiotics, how many times? _____

Any known allergies to foods, medication, supplements, animals or environment?

FAMILY MEDICAL HISTORY

	Age/Age at death	General health (excellent, good, poor)	Health conditions
Mother/Father			
Mother/Father			
Sibling 1			
Sibling 2			
Maternal Grandfather			
Maternal Grandmother			
Paternal Grandfather			
Paternal Grandmother			
Other			

* Parents of same sex families, please indicate the name of each parent listed.

Was your child adopted? ❑ Yes ❑ No If yes, at what age: _____

GENERAL HISTORY:

(For the following list of symptoms: √ for currently experiencing and P for those you've had in the past)

SKIN:
- ❑ Rashes
- ❑ Eczema
- ❑ Psoriasis
- ❑ Cradle cap
- ❑ Diaper rash
- ❑ Vitilago
- ❑ Dryness
- ❑ Hives
- ❑ Acne
- ❑ Warts
- ❑ Change in skin texture

HEAD:
- ❑ Head injury
- ❑ Headaches/Migraine
- ❑ Vertigo/Dizziness
- ❑ Hair loss
- ❑ Dandruff
- ❑ Change in hair texture
- ❑ Head lice

EYES:
- ❑ Redness
- ❑ Pink eye
- ❑ Excessive tearing
- ❑ Discharge/infection
- ❑ Eye pain

EARS:
- ❑ Infection
- ❑ Ringing
- ❑ Hearing loss

NOSE & SINUSES:
- ❑ Frequent colds
- ❑ Nasal stuffiness
- ❑ Loss of smell
- ❑ Nose bleeds
- ❑ Nasal polyps
- ❑ Sinus infections
- ❑ Chronic runny nose

CHILDHOOD ILLNESS
- ❑ Chickenpox
- ❑ Hand Foot & Mouth
- ❑ Mumps
- ❑ Fifths Disease
- ❑ Measels/Mumps
- ❑ Impetigo

MOUTH & THROAT:
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Periodontal disease
- ❑ Thrush
- ❑ Recurrent sore throat
- ❑ Enlarged lymph nodes
- ❑ Torticollis/stiff neck
- ❑ Peculiar tastes
- ❑ Production of mucus

RESPIRATORY:
- ❑ Cough
- ❑ Wheezing
- ❑ Asthma
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Coughing blood

CARDIOVASCULAR:
- ❑ Heart murmurs
- ❑ Rheumatic fever
- ❑ Difficult breathing
- ❑ Leg cramps
- ❑ Edema/swollen ankle
- ❑ Cold hands/feet

INTESTINAL
- ❑ Colic
- ❑ Finicky eater/Poor eater
- ❑ Trouble swallowing
- ❑ Nausea
- ❑ Vomiting
- ❑ Heartburn/regurgitation
- ❑ Stomach aches
- ❑ Bad breath
- ❑ Bloating
- ❑ Excessive gas
- ❑ Ulcer
- ❑ Hypoglycemia
- ❑ Diabetes
- ❑ Jaundice/hepatitis
- ❑ Colitis or Crohn's
- ❑ Constipation
- ❑ Blood in stool
- ❑ Diarrhea
- ❑ Hemorrhoids
- ❑ Eating disorder

GENITOURINARY:
- ❑ Bedwetting
- ❑ Urgency
- ❑ Dribbling/leaking
- ❑ Frequency
- ❑ Incontinence
- ❑ Burning pain
- ❑ Urinary tract infections
- ❑ Kidney infections
- ❑ Kidney stones
- ❑ STDs (HPV, etc.)

GENERALS:
- ❑ Weight loss
- ❑ Weight gain
- ❑ Fatigue
- ❑ Night sweats
- ❑ High fever
- ❑ Profuse perspiration
- ❑ Weakness
- ❑ Insomnia/poor sleep
- ❑ Nightmares

FEMALE:
- ❑ Early Puberty (before 11)
- ❑ Painful menstrual cramps
- ❑ PMS

BEHAVIOUR:
- ❑ Tantrums
- ❑ Easily angered
- ❑ Hyperactivity
- ❑ Extreme shyness
- ❑ Separation anxiety
- ❑ ADD
- ❑ ADHD

HAEMATOLOGICAL
- ❑ Anemia
- ❑ Easy bleeding
- ❑ Easy bruising
- ❑ Varicose/spider veins
- ❑ Past transfusions
- ❑ Hep. A, B, or C
- ❑ HIV

MUSULOSKELETAL
- ❑ Muscle pains
- ❑ Joint pains
- ❑ Juvenile arthritis
- ❑ Back pain
- ❑ Muscle spasms/cramps
- ❑ Joint swelling

NEUROLOGICAL:
- ❑ Fainting/black-outs
- ❑ Numbness
- ❑ Pins & needles
- ❑ Loss of balance
- ❑ Nervousness/tension
- ❑ Irritability
- ❑ Depression
- ❑ Autism
- ❑ Asperger's
- ❑ Seizures

WEIGHT:

_____

HEIGHT:

_____

PRENATAL HISTORY

What age was mother at child's conception? _____ Father's age at conception?_____

Parents health at conception (E=excellent, G=good, P=poor) M: _____ F: _____

Was your child conceived naturally? ❑ Yes ❑ No

Was there any difficulty conceiving this child? ❑ Yes ❑ No

Any fertility interventions? ❑ Yes ❑ No If yes, explain:

Any illnesses, medications or exposures to toxins during pregnancy?

EARLY CHILDHOOD HISTORY

Anything notable about labour and delivery? Please describe:

Vaccinations: Did your child receive vaccinations? ❑ Yes ❑ No
Describe reactions to vaccinations, if any:

Does your child have any unusual habits?

Does your child have any fears?

How is your child's behaviour at home?

Is your child in: ❑ school ❑ homeschool ❑ other What grade level? _____

General school behaviour and performance:

Has your child been diagnosed with any learning disabilities?

Does your child make friends easily?

Child's interests and favourite activities?

How many hours/week does your child:
❑ Play on the computer or video games _____ ❑ Watch TV _____
❑ Read (not for school) _____ ❑ Exercise _____

Please describe your child's personality:

NUTRITION

Was the child breast-fed? ❑ Yes ❑ No If "yes", until what age?_____

If "no", what type of formula or other liquid was used?_____

At what age were solid foods introduced?_____

Describe any noticeable reactions to foods introduced (rashes, changes in sleeping habits)

Describe any dietary restrictions (food intolerances/allergies, religious, vegetarian, vegan, etc.)

Describe any food cravings:

Describe any food aversions:

List your child's dietary intake for the last 24 hours.

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

What is the source of your household's drinking water?

❑ Well ❑ Tap ❑ Filtered ❑ Distilled ❑ Bottled spring ❑ Reverse osmosis

ENVIRONMENT

Is your child sensitive to any of the following? Please circle

Cold	Heat	Wind	Drafts	Smell
Height	Sunlight	Music	Wool	Small spaces
Other:				

SLEEP

Describe any issues your child has regarding bedtime, naps, falling asleep, etc:

ANYTHING ELSE?

Please include any other information that hasn't already been described in these forms that you would like to share with us.