Dr. Linda L. Brown, BA, ND

CHILD INTAKE FORM (age 12 and under)

Patient:
Name: ___________________________________ Date: _________________ Sex: M F
Birthdate: _____________________ Age: _____ Height: __________ Weight: ________
Address: ____ Apt.# _________
Number Street
____
City Province Postal Code
Home# _____________________ Who does the child live with? ________________________

Name and Relationship of person filling out this form? _________________________________

Parent/Guardian: ***Email Address***: ____
Name: ________________________________ Relationship: ______________________________
Address: ____ Apt. # _____________
Number Street
____
City Province Postal Code
Home# __________________ Work# _________________________ Cell# __________________

Additional Contact Person (in case of emergency)
Name: ______________________________ Relationship: ________________________________
Address: ____ Apt# ________________
Number Street
____
City Province Postal Code
Home# ____________________ Work# ________________ Cell# _______________________

Family Physician
Name: __________________________ Telephone #: ____________________
Address: ____
Number Street City Province Postal Code

Were You **Referred**? _________ By Whom? ______________________

Other Health Practitioners
Name: __________________ Telephone#: _____________ Specialty: __________________
Address: ____
Number Street City Province Postal Code

Home Information
Marital Status of Parents/Guardians?____________ Is the child from a stable home? _________
Number of Siblings? ____ Birth order of this child? ____ Adopted? _____ Planned birth? ______

Primary Complaint
What is the Chief Concern today? ____
Since when? _________ What prior treatment? _________________ Result?________________

Secondary Concerns, in order of Importance:
1. ________________________ 2. ______________________ 3. ___________________________

Medical History

The child's general state of health is (circle): Excellent Good Fair Poor

Screening tests the child has undergone (circle): Blood Urine Vision Hearing Other ___________

List serious conditions and approximate dates of hospitalizations, surgeries, major illnesses:
____
____

List any allergies (ie. drugs, environmental, hayfever, etc.): ________________________________
____

List any medications the child is currently using (and for what conditions). Include prescription drugs, vitamin supplements, homeopathics, herbs, etc. :____
____
____

List any past medications, and how long the child was using them: ___________________________
____
____

How many times has the child been treated with antibiotics (approx.)? ________

Has the child had any of the following (circle):

Measles	Mumps	Chicken Pox	Rubella (German Measles)
Impetigo	Roseola	Scarlet Fever	Mononucleosis
Strep Throat	Ear Infections	Frequent Colds	Whooping Cough

Were any of these extremely severe? ____

Which Immunizations has the child received? (circle):

Tetanus booster	MMR (measles, mumps, rubella)	Polio
Hemophilus Influenza B	DPT (Diphtheria, pertussis, tetanus)	Flu
Hepatitis A	Hepatitis B	Others _____________

Adverse reactions? _____ If so, what? ___________________________________

Prenatal History

Circle any difficulties experienced during pregnancy with this child:

Emotional Trauma	Gestational Diabetes	Physical Trauma
Excess Bleeding	High Blood Pressure	Thyroid Problems
Excess Weight Gain	Nausea/Vomiting	Toxemia

Other: ____

Was the mother exposed to disease or toxins during pregnancy? Y N Unknown. Which?____________
Did the mother travel during pregnancy? _______ If so, where and for how long? _____________________
Did the mother work during pregnancy? _______ If so, how strenuously? _______ Until when? __________
Was there any alcohol, drug (prescription or recreational), tobacco, or supplement used during pregnancy with this child? Please describe. ____
Mother's diet during pregnancy?(circle) Excellent Good Fair Poor Unknown
Mother's health during pregnancy? (circle) Excellent Good Fair Poor Unknown
Did the mother receive prenatal care? _______

Neonatal History

Did the infant experience any of the following? (circle): Low weight Excess Weight Gain
Respiratory distress Anemia Rashes Colic Infections

Sleeping Habits

Please describe sleep: During first year of life ________________________ Now __________________
# of hours of sleep per night? ____ Needs a nap? ______ At what time, and for how long? ___________
What time is normal bedtime? ____________________

Does the child have trouble with (circle): Staying awake Falling Asleep Nightmares
Bedwetting Sleepwalking Sleeptalking Grinding Teeth Other Unusual Habits

Feeding History

Breastfed? ______ On Demand? _____ For how long? _______
Formula? _______ What kind? (circle): Soy Cow's Milk Other _____________

Are there any dietary restrictions (religious, vegetarian, etc.)? ______________________________

List the foods introduced before 6 months ____
____

List foods introduced from 6 – 12 months ____
____

Any food allergies/intolerances? _______________________ Season allergies? _________________

Describe the child's **diet** on a typical day:
Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____
Drinks (type and quantity): ____

Bowel Movement Frequency? (circle) More than once/day Once/day Once/wk Less often
Urinary Frequency? ______ times/day. Anything unusual (colour/odour/amount)? ________________

Behavioural/Emotional

How would you describe the child's temperament? Well-adjusted Separation Anxiety Shares
Performance Anxiety Independent Confident Outgoing Withdrawn Depressive
Plays well alone Plays well with others

List Fears: ____

Describe Relationships:
With Friends: ____________________ With Siblings: _________________________
With Other Relatives: _________________ With Teachers: __________________________

Temper tantrums? Y N Aggressive? Y N How disciplined? ________________________

Interest/Activities/Hobbies ____

Parents' Health and Family History
Parents' age at conception: Mother _______ Father ________
Number of previous pregnancies? _____________ Live births? ___________
General medical health of parents at time of conception. Please circle:
Mother: Excellent Good Fair Poor Unknown
Father: Excellent Good Fair Poor Unknown

Please describe the current health of both parents:
Mother: Excellent Good Fair Poor Unknown
Father: Excellent Good Fair Poor Unknown
Do the parents smoke? Mother Y N Father Y N

Indicate if a Parent, Grandparent or Sibling has had any of these conditions:

	Who?		**Who?**
Allergies		Diabetes	
Asthma		Heart Disease	
Birth Defects		Juvenile Diabetes	
Cancer		Kidney Disease	

Other conditions: ____
Is Family History Unknown? Yes___ No___

Birth History
Full-term? Y N Premature (___ weeks) Late (___ weeks)
Length of Labour? _______
Mother's emotional state during and after delivery? __________________________________

Were there complications? ____

(Circle): Vaginal birth Induced Caesarian

Interventions?: Drugs Pitocin Suction Forceps Epidural Episiotomy

Height at birth ______________ Weight at birth ______________
Apgar Score ________________ Head Circumference ___________________

Were any of the following experienced by the child during/after delivery?
Birth Defects Birth Injuries Seizures Jaundice Rashes Other _______________
Where was the child delivered? Hospital Delivery Room Birthing Room Home Car Other _______

Development
Describe the child's health in the 1st year: Excellent Good Fair Poor
Child's growth/size have been: Average Faster/Bigger than average Slower/Smaller than avg

	At What Age?		**At What Age?**
Rolling Over	___________	Talking	___________
Sitting Alone	___________	Toilet Training	___________
Crawling	___________	Teeth	___________

Walking ___________

Describe the child's performance at school/intellectual ability ________________________________

Review of Systems: (Please circle)

Head:	Rash	Dry Skin	Cradle Cap	Itchy Scalp	Fever	
Eyes:	Redness	Discharge	Rubbing	Lazy Eye		
Ears:	Pain	Rubbing	Discharge	Impaired Hearing		
Nose:	Congestion	Redness	Discharge	Allergy	Bleeding Nose	
Mouth:	Cold Sores	Teething	Drooling	Bad Breath	Cavities	Thirsty
Skin:	Rash	Birthmark	Dryness	Eczema	Moles	Freckles	Itchiness
Neck/Throat:	Swollen glands	Sore throat	Difficulty Swallowing	Painful Movement		
Respiration:	Coughing	Hiccup	Congested lungs	Wheezing		
Cardiovasc:	Pale	Bluish Skin	Sweating	Palpitations	Varicose Veins	
Gastrointest:	Vomit	Food Reaction	Abd swelling	Diarrhea	Constipation	Bleeding
Genitourin:	Pain	Rash	Redness	Discharge	Blood in urine	Poor bladder control
Musculosk:	Fracture	Sprain	Limp	Joint/Muscle Pain	Curved Spine	Food deformity
Neurologic:	Seizure	Tremor	Lethargic	Irritable	Jumpy	

List any countries the child has travelled to, and when:
____

Is the child sensitive to (circle): Hot Cold Music Bright Lights

Child's Environment:

How much exercise does the child get? _____ hrs/day ________ hrs/week
Does the child play outside? _________
How much television does the child watch? ______ hrs/day _________ hrs/week
How much computer time/video games? ________ hrs/day __________ hrs/week
Does the child have a cell phone? ______ How much texting time? _____hrs/day _____ hrs/week
How much reading does the child do for pleasure (or how often is the child read to)? Please circle:
Daily Several times per week Weekly Monthly Rarely
Is the child most often at: Home School Daycare Babysitter Other_____________
Are there any pets in the home? Y N. What kind?_______________ Known allergies to pets?________
What type of heating is in the home? ________________________________
Are there any hazards or toxins the child is exposed to? Please describe.
____

Do you have any other concerns not previously mentioned?
____

What are your goals for bringing this child in today?
____

ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL.

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