CHILD INTAKE FORM
(Ages 10 & under)

PERSONAL INFORMATION:

Name: ____ Date: _________________

Address: _____________________________________ City: ________________ Province: ______

Postal Code: ____________

Telephone: Home: ________________ Cell: ________________ Work: ________________

E-mail: ____

Date of Birth: ____________ Age: ___ Sex: ___

Caregiver's Name(s): ____________________________ Relationship: ____________________

Emergency Contact: ________________________________ Phone Number: ________________

Do you have extended health insurance? __ Yes __ No

If yes, please list provider: ______________________________________

How did you hear about The Nardella Clinic? ____________________________________

I would like to be on the clinic's general mailing list to receive clinic information, such as subscriber specials and the clinic newsletter. Please circle YES/NO.

Siblings Names:

____________________ Age: _____________

____________________ _____________

____________________ _____________

____________________ _____________

Family MD/ Pediatrician: ____

Address: ____ Phone Number: __________________

Midwife/Obstetrician (children under 2): ____

Address: __________________________________ Phone Number: ________________________

PRENATAL HISTORY

Please indicate any conditions experienced by the mother of this child during pregnancy:

____ Diabetes ____ Edema (Swelling) ____ Emotional Trauma

____ Fainting ____ German measles ____ Herpes

____ Hypertension ____ Infections ____ Nausea

____ Vomiting ____ Thyroid Problems ____ Physical Trauma

____ Weight loss ____ Excessive Weight Gain

____ Pregnancy Induced Hypertension Other: _______________________________

Please list supplements/medications taken by the mother during her pregnancy with this child: ____

Please indicate any of the following items this child's mother used during her pregnancy and frequency:

__ Cigarettes __________/day __ Alcohol ___________/week

__ Caffeine ____________/day __ Drugs (type) ______________________/week

Was there any history of a complicated pregnancy before the birth of this child? _________
If yes, please describe:
____

BIRTH HISTORY

Length of gestation ________________________ Length of labour ______________________
Was labour spontaneous? __________ If not, how was it induced? ______________________
Type of delivery: ___ vaginal ___ C-section ___ Emergency C-section
Were there any interventions used during the birth of this child? ___ Yes ___ No
If yes, what type? ____
What was this child's weight at birth? ____________

Were any of the following experienced at or soon after this child's birth?

___ Allergic reactions	___ Birth Defects	___ Colic
___ Difficulty Feeding	___ Fevers	___ Failure to Thrive
___ Hypoxia	___ Jaundice	___ Meningitis
___ Rashes	___ Seizures	___ Unusual Weight Gain
___ Unusual Weight Loss	___ Respiratory Difficulties	

Other: ____
When did these problems begin? ____
What treatments have you tried for these health concerns? __________________________
____
Did this child undergo any of the following interventions?

___ Medications	___ Respirator	___ Surgery
___ Billi-Lights	___ Incubation	

CHILD'S HEALTH HISTORY

What is your major health concern regarding this child?
____
____
What other concerns do you have?
1. _____________________________
2. _____________________________
3. _____________________________
Does the child sleep during the night? _________________ Number of hours ____________
What is the child's napping pattern during the day? __________________________________
Does this child suffer nightmares? ____
Does this child have any known allergies? ____
If yes, what allergies?
____
____

Has this child ever been hospitalized? ___
If yes, when and what for? ____
____
____

Please list any medications or supplements this child is taking or has taken:
Currently: ____
Has Taken: ____

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Please indicate any of the following that pertain to the child:

____ Allergies	____ Bed Wetting	____ Asthma
____ Bladder Infections	____ Blood in Urine	____ Body/ Breath Odour
____ Bronchitis	____ Burning Urine	____ Chicken Pox
____ Colds	____ Constipation	____ Cough
____ Cradle Cap	____ Croup	____ Diarrhea
____ Ear Infections	____ Easy Bleeding	____ Easy Bruising
____ Eczema	____ Emotional Trauma	____ Eye Infections
____ Fatigue	____ Fever	____ Fracture
____ Frequent Urination	____ Fungal Infections	____ Gas
____ Growing Pains	____ Hair Loss	____ Hearing Problems
____ Lice	____ Measles	____ Meningitis
____ Mood Changes	____ Mumps	____ Nausea
____ Nervousness	____ Night Sweats	____ Nose Bleeds

Please indicate any of the following that applies:

__ Pneumonia	__ Physical Trauma	__ Rash
__ Rheumatic Fever	__ Rubella	__ Scarlet Fever
__ Seizures	__ Sleeping Problems	__ Sore Throat
__ Stomach Flu	__ Strep Throat	__ Tonsillitis
__ Unusual Fears	__ Vision Problems	__ Vomiting
__ Walking difficulties	__ Crawling Difficulties	__ Whooping Cough

FAMILY HISTORY

Mother's age at time of child's conception ____________
Father's age at time of child's conception _____________
Describe mother's health at time of child's conception ______________
Describe father's health at time of child's conception ______________

Please mark a check by any of the following that pertain to the child's immediate family:

____ Allergies	____ Arthritis	____ Asthma
____ Autoimmune Disease	____ Birth Defects	____ Bleeding disorders
____ Cancer	____ Hearing loss	____ Depression
____ Diabetes	____ Eczema	____ Heart Disease
____ Hepatitis	____ Herpes	____ HIV or AIDS
____ Hypertension	____ Kidney Disease	____ Mental Illness
____ Peptic Ulcer	____ Thyroid Disease	____ Tuberculosis
____ Visual Problems		

Other: ____________________________________

SOCIAL HISTORY

Describe this child's general temperament ______________________________
Describe this child's interaction with others ____
Has this child experienced any emotional trauma? ______________________________________
How does this child handle stress? ____
How does this child express his or her emotions? _______________________________________
Describe this child's performance at school? ______________________________
How do you feel other people would describe this child? _________________________________

Have you ever noticed any behavioral problems with this child at school/daycare/sitters? If yes, please describe:

____
____

Does this child take part in any extracurricular activities? _______ If yes, please describe:

____

IMMUNIZATION HISTORY

Please indicate approximate dates where relevant:

Measles ____________	Mumps _____________	Rubella _____________
Polio _______________	Small Pox ___________	Influenza____________
Hepatitis____________	Chicken Pox_________	Diphtheria___________
Pertussis____________	Tetanus_____________	Other_______________

Please indicate any of the following adverse or odd reactions that this child may have experienced after receiving his/her immunizations:

____ Swelling	____ Joint Pain	____ Limping
____ Mood Changes	____ Rash	____ Fever
____ Excessive Crying	____ Pain	____ Loss of Appetite
____ Vomiting	____ Insomnia	

Other____

NUTRITIONAL HISTORY

Was this child breastfed? __________________ If yes, for how long? _______________________
If no, please indicate what food and brand was used ____________________________________
Excluding water and breast milk, what was the first liquid introduced to this child?

Please list solid food items in the order they were introduced to this child:

Food	Age of Introduction
___________________________________	____________________
___________________________________	____________________
___________________________________	____________________
___________________________________	____________________
___________________________________	____________________

Were any adverse reactions to these above foods or any other foods noticed?
If yes, what were these foods? ____

____

Does this child have any dietary restrictions? (ex: Religious, vegan, vegetarian)
____

HOME ENVIRONMENT

How many people live in the same home as this child? ____________________________
Is the child exposed to any of the following at home: _____Smoking
_____Pets
How old is the home this child lives in? ______________________________________
Describe the emotional environment in which this child lives?
____

Please add any additional information you feel would be helpful regarding this child.
____
____
____
____

INFORMED CONSENT

I would like to take this opportunity to welcome you to the clinic. This Clinic utilizes the principles and practices of Naturopathic Medicine and supplemental therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.
Your practitioner will conduct a thorough case history, which may include a physical exam and specific laboratory testing as part of the treatment. Any practitioner you choose to work with will have access to your history to minimize repetition while maintaining complete confidentiality.

Statement of Acknowledgement

I, (printed name) ____ as a patient of this clinic, have read the information and understand that the form of medical care is based on Naturopathic and other supportive principles and practices. As the clinic is an integrated health clinic, I recognize that all the practitioners that are working with me will have access to my file. I also recognize that even the gentlest of therapies potentially have their complications in certain physiological conditions, in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but are not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs, pain, fainting, bruising or injury from venipuncture or acupuncture; and muscle strains and sprains.
I also confirm that I have the ability to accept or reject this care of my own free will and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so declaring.
I understand that, as a patient, I am responsible for all costs incurred as a result of the decision including, but not limited to; the cost of all procedures involved in the treatment plan, the care provider's time, supplements, supplies and appointments missed or cancelled without sufficient notice (48 hours). I am aware that all telemedicine appointments will be charged to the credit card on file seven (7) days in advance of the appointment. I am aware that treatments are not covered through Alberta Health Care and may not be covered under private health insurance.

______________________________ ______________ ____________________
Signature of Parent or Guardian Date Witness

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