Summerside Naturopathic

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PLEASE COMPLETE THIS FORM AND RETURN IT TO
DR. MORRISON PRIOR TO YOUR APPOINTMENT

Child Intake

(please print clearly)

Name ______________________________ **Date** ______________

Date of birth ____________________ (M/D/Y) **Sex M F**

Address:____
____
____
____

E-mail Address:____

Telephone number: Home:____________________ **Cell**:____________________

May we leave messages relating to your visits? Y / N Work: ____________________

Emergency contact: Name: ______________________________________

Phone number:________________ **Relation**:____________________

How did you hear about our Clinic:__________________________________

Other health care providers the child is seeing: (Name, Address, Phone)

1. ____________________	**2.** ____________________	**3.** ____________________
____________________	____________________	____________________
____________________	____________________	____________________
(_____)________________	(_____)________________	(_____)________________

What are your child’s health concerns:

1. ____
2. ____
3. ____
4. ____
5. ____

Medical history

How would you describe your child’s general state of health? Good Fair Poor
Which of the following has your child had? (n-never, rn-mild, a-average, s-severe)
please circle:

n m a s rubella (german measles)
n m a s measles
n m a s chickenpox
n m a s mumps
n m a s roseola
n m a s scarlet fever
n m a s strep throat
n m a s whooping cough
n m a s impetigo
n m a s mononucleosis
n m a s ear infections

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates.

____
____
____
____

Does your child have any allergies (medicines, environmental, etc.)?

____
____
____
____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

____
____
____
____

Please list past prescription medications.

____

____

____

____

How many times has he/she been treated with antibiotics?
When and for what reason?

____

____

Please indicate what immunizations your child has had or check Standard childhood vaccinations, if it applies.

- ☐ **DPT (diphtheria, pertussis, tetanus)**
- ☐ **Tetanus booster; when?** ____________________________
- ☐ **MMR (measles, mumps, rubella)**
- ☐ **Haemophilus influenza B**
- ☐ **“Flu”**
- ☐ **Flu shot annually**
- ☐ **Polio**
- ☐ **Hepatitis A**
- ☐ **Hepatitis B**
- ☐ **Smallpox**

- ☐ **Swine flu**
- ☐ **Gardasil**

- ☐ **Standard Childhood vaccinations**

Please indicate if any caused adverse reactions:

____

____

<u>Prenatal Health</u>

What was the state of the Mother during pregnancy? Poor Fair Good Excellent Unknown
What was the mother’s age at child’s birth? ________
How was the mother’s diet during pregnancy? Poor Fair Good Excellent Unknown
Did the Mother receive prenatal medical care? Y N Unknown

Did the mother experience any of the following during pregnancy? (Circle)

bleeding   high blood pressure   nausea   vomiting   diabetes

Thyroid problems   Physical or emotional trauma

Other?

____

Did the Mother use any of the following during the pregnancy? (Please give details)

Tobacco ____

Alcohol ____

Recreational drugs ____

Prescription drugs ____

Over-the-counter medication____

Supplements ____

Other ____

Birth History

Term length: Full Premature ________wks Late ____________wks
Length of labour: ___________________ **Weight at birth:** _____________
Complications?
____

Was the birth: Vaginal C-section Induced Forceps
Anaesthesia used

Did the child experience any of the following symptoms after birth?
Jaundice Rashes Seizures Birth injuries ________________________

Birth defects____
Other?
____

Diet

How was your infant fed?
Breast fed. How long? _________________ **Formula. Milk or Soya?**
Other ______________________________________

What foods were introduced before 6 months (please list approximate months as well):

6-12 months?

Did your child ever experience colic? Y N How severe? Mild moderate severe

Does your child have any food allergies or intolerances? Please list.

Describe a typical day's diet:

Breakfast
Lunch
Dinner
Snacks

Beverages (and total quantity)

Family history

Do either of the parents have a chronic illness? Y N Please describe:

Mother:

Father:

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

	Who?		Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug abuse/alcoholism	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes			

☐ **I don't know my family medical history**

Health and Development

How was your child's health in the first year? Poor Fair Good Excellent Unknown

At what age did your child, first:

Sit up ________ Crawl _________ Walk _________ Talk _____
Describe your child's sleep pattern:

How would you describe your child's temperament?

How would you describe your child's behaviour and performance at school?

Environment

Is your child in: school (grade? ______) daycare homecare other: ___________________

What are your child's favourite activities?

Does your child exercise regularly? Y N How much, how often?

How much television does your child watch? __________ hrs a day/ week____________
How often does your child read (not for school), or How often does someone read to your child? Daily? Several times per week?

Are there animals in the home? Y N Type: _____________________

How is your child's home heated? ____________________________

Do you know of any toxins or other hazards the child is regularly exposed to (home, hobbies etc?)

How would you describe the emotional climate of the child's home?

Is there anything that you feel is important that has not been covered?

____

____

For file use only.