Child Intake Form (ages 1 to 5)

Child's Name ________________________________ **Date:**__________________
Date of Birth: M:_____ D:_____ Y:_____ **Sex**: M F

How did you learn of St. Albert Naturopathic Clinic? ___________________________

Parent/Guardian Information:

Name _______________________________ Relationship to child ____________
Email _______________________________

Address _____________________________ Phone ____________________(home)
_____________________________ ____________________(work)
_____________________________ ____________________(cell)

Other health care providers
1. ____________________ 2. ____________________ 3. ____________________
____________________ ____________________ ____________________
____________________ ____________________ ____________________
(___) ________________ (___) ________________ (___) ________________

Please list your child's health concerns, in order of importance:
1. ____
2. ____
3. ____
4. ____

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

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

Which of the following has your child had?

rubella (german measles)	_____	roseola	_____	impetigo	_____
measles	_____	scarlet fever	_____	mononucleosis	_____
chicken pox	_____	whooping cough	_____	ear infections	_____
mumps	_____	strep throat	_____		

Does your child have any allergies (medications, environmental)?
____
____

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

Please list past prescription medications.
____
____

How many times has your child been treated with antibiotics? _________

Has your child been immunized? Yes No

Diet

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

Does your child have any dietary restrictions (religious, vegetarian / vegan, etc.)?
____

Describe a typical day's diet

Breakfast ____
Lunch ____
Dinner ____
Snacks ____
Beverage (and total quantity) ____

Family History

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

	Who?		Who?
Allergies		Diabetes	
Asthma		Kidney disease	
Birth defects		Other	
Juvenile arthritis		Other	

___ I don't know the family medical history.

Do either of the parent have a chronic illness? Yes No (*Please describe.*)

____

Environment

Is the child in: school daycare home care

What are your child's favourite activities? ___________________________________

Does the child exercise regularly? Yes No

How much television does your child watch? __________ hours per day / week

How often does someone read to your child? __ Daily __Several times/week __Weekly

Does anyone in the child's household smoke? Yes No

Are there animals in the house? Yes No

Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)? Please describe: ___________________________________

____

How would you describe the emotional climate of the home? _____________________

Is there anything that you feel is important that has not been covered? Yes No

____

____

____