ST. ALBERT NATUROPATHIC CLINIC

Infant Intake Form (ages 0 to 12 months)

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)
_____ _____(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? (n=never, m=mild, a=average, s=severe)

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

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

_____

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_____

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? _____

Please indicate what immunizations your child has had: (check off)

___ DPT (diptheria, pertussis, tetanus) ___ Haemophilus influenza B ___ Hepatitis B
___ Tetanus booster; what?_____ ___ Flu shot ___ Hepatitis A
___ MMR (measles, mumps, rubella) ___ Polio ___ other _____

Please indicate if any caused adverse reactions:

_____

What screening tests has your child had (blood, hearing, vision, etc.) _____

_____

Prenatal Health

What was the health of the parents at conception?

Mother: Poor Fair Good Excellent Unknown
Father: Poor Fair Good Excellent Unknown

What was the health of the mother during pregnancy? Poor Fair Good Excellent
What was the mother's age at child's birth? _____
Did the mother receive prenatal medical care? Y N Unknown

Did the mother experience any of the following during the pregnancy:

___ 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?

___ Tobacco ___ Alcohol ___ Recreational drugs :_____
___ Prescription medications:_____
___ Over-the-counter medications: _____
___ Supplements: _____
___ Other: _____

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Birth History

Term length: ___ Full ___ Premature ___ Late
Length of labour: _____ Weight at birth: _____
Any complications? _____

Was the birth: (circle) Vaginal / C-section Induced Forceps Anesthesia used

Did the child experience any of the following at or shortly after birth? (check off)
___ Jaundice ___ Rashes ___ Seizures ___ Birth injuries: _____
___ Birth defects: _____
___ Other: _____

Diet

How was your infant fed?
___ Breast fed. (How long? _____) ___ Formula. Milk / Soy / Other: _____

What foods were introduced before 6 months of age? (Please list approximate month as well.)
_____
_____

Between 6 –12 months? _____
_____

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

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

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

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? Y N Please describe _____

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Environment

How often does someone read to your child?

___ Daily ___ Several times a week ___ Weekly ___ Less than weekly

Does anyone in the child's household smoke? Y N

Are there animals in the house? Y N

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?

_____
_____

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