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ACTIVE BACK TO HEALTH CENTRE
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CHILDREN’S INTAKE FORM

Child’s Name: _____
(Last name) (First name) (Middle name)

Age: _____ **Gender:** Female Male **Date of Birth:** ____/____/____

Address: _____
(street address) (city) (province) (postal code)

Telephone: Home _____ Work _____ Cell _____

Email: _____

How did you hear about our office? _____

Emergency Contact: _____
(name) (relationship) (telephone)

Who is your child’s family physician? _____

Date of last physical exam: _____

PLEASE COMPLETE THE FOLLOWING QUESTIONS

Please list your current health concerns in order of importance:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Please list all medications, over the counter medications, vitamins and supplements your child is currently taking, the dosage and the main reason for taking them:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

MEDICAL HISTORY

Does your child have any drug allergies?

1. _____
2. _____
3. _____

List all surgeries your child has had:

_____ year? _____ purpose? _____
 _____ year? _____ purpose? _____
 _____ year? _____ purpose? _____

HEALTH HISTORY

Has your child experienced any of the following conditions?

| | | | |
|---------------------------|----------------|--------------------------|----------------|
| Allergies-seasonal | [] yes [] no | Diarrhea | [] yes [] no |
| Allergies-environmental | [] yes [] no | Difficulty concentrating | [] yes [] no |
| Appendicitis | [] yes [] no | Difficulty sleeping | [] yes [] no |
| Atopic dermatitis | [] yes [] no | Ear infection | [] yes [] no |
| Asthma | [] yes [] no | Eczema | [] yes [] no |
| Bronchitis | [] yes [] no | Frequent colds | [] yes [] no |
| Cancer | [] yes [] no | Hay fever | [] yes [] no |
| Chicken pox | [] yes [] no | Head lice | [] yes [] no |
| Chronic bedwetting | [] yes [] no | Hyperactivity | [] yes [] no |
| Chronic nose bleeds | [] yes [] no | Impetigo | [] yes [] no |
| Chronic bruising | [] yes [] no | Measles | [] yes [] no |
| Cold sores | [] yes [] no | Meningitis | [] yes [] no |
| Colic | [] yes [] no | Mumps | [] yes [] no |
| Conjunctivitis (pink eye) | [] yes [] no | Pneumonia | [] yes [] no |
| Constipation | [] yes [] no | Sinusitis | [] yes [] no |
| Convulsions | [] yes [] no | Skin rash | [] yes [] no |
| Cradle cap | [] yes [] no | Strep throat | [] yes [] no |
| Croup | [] yes [] no | Thrush | [] yes [] no |
| Diabetes | [] yes [] no | Tonsillitis | [] yes [] no |
| Diaper rash | [] yes [] no | Urinary tract infection | [] yes [] no |

VACCINATIONS

| | |
|--|---------------------------|
| Hepatitis B | Age: Adverse reaction: |
| DPT or DT- Diphtheria, Pertussis, Tetanus | Age: Adverse reaction: |
| Polio | Age: Adverse reaction: |
| Hemophilus B | Age: Adverse reaction: |
| MMR-Measles, Mumps, Rubella | Age: Adverse reaction: |
| Tetanus | Age: Adverse reaction: |
| Varivax (Chicken pox) | Age: Adverse reaction: |
| Other | Age: Adverse reaction: |

If a sibling of the child has had an adverse reaction to any vaccinations please describe the reaction here:

PRE-NATAL HEALTH AND BIRTH HISTORY

| | Excellent | Good | Fair | Poor | Not sure |
|---|------------------|-------------|-------------|-------------|-----------------|
| How was the health of the mother at time of conception? | | | | | |
| How was the health of the father at time of conception? | | | | | |
| How was the health of the mother during the pregnancy? | | | | | |
| How was the emotion state of the mother during pregnancy? | | | | | |
| How was the mother's eating habits during pregnancy? | | | | | |

Did the mother receive any medical care during pregnancy?

Did the mother use any alcohol, cigarettes or recreational drugs during pregnancy?

Did the mother use any prescription drugs during pregnancy?

Did the mother use any over the counter medications during pregnancy (i.e. Tylenol, Aspirin)?

Did the mother take any supplements or vitamins during pregnancy?

Were there any interventions used during the pregnancy (i.e. epidural, forceps, vacuum)?

Weight of infant at birth: _____ lbs

Term length of pregnancy:

- [] pre-term (37 weeks or less): _____ weeks
- [] full-term (38-42 weeks): _____ weeks
- [] post-term (42 weeks or more): _____ weeks

Did the infant experience any of the following conditions during or following the birth?

- [] injuries during the birth: _____
- [] birth defects: _____
- [] jaundice: _____
- [] infections: _____

| |
|------------------|
| LIFESTYLE |
|------------------|

- What time does your child go to bed? _____ Wake up? _____
- Does your child take naps? _____ When? _____
- Do they have any trouble falling asleep? _____
- Do they sleep through the night? _____
- Do they wake up well-rested? _____
- Do they have any bad dreams or nightmares? _____

How would you describe your child as he/she is presently in terms of personality, general characteristics and any traits that are unique to your child: _____

Is your child currently in school, daycare, at home? _____

How would you describe your child's behavior in school/daycare? _____
Does this differ greatly from behavior at home? _____

What makes your child angry? _____

How does he/she express anger? _____

Do they express their emotions easily? _____

Do they experience any uncontrollable emotions (i.e. anger, aggression, crying)? _____

List any significant or traumatic events in your child's life: _____

Does your child have any fears? _____
What does your child do when afraid? _____

FOOD INTAKE HISTORY

Breast fed How long? _____ easy difficult
Approximate feeding schedule? _____

Formula fed How long? _____
What type of formula was used? milk soy goat other

At what age was solid food first introduced? _____
What types of foods were introduced and in what order? _____

Did your child have any reactions to foods being introduced? _____

Does your child have any food allergies? _____

Does your child have any dietary restrictions (i.e. religious, vegetarian)? _____

Typical diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Does your child have any cravings or aversions (please list)? _____

Does your child avoid certain foods? Why? _____
