

CHILD INTAKE FORM

This form is completely confidential. Please submit by email, fax, mail, or in-person **3 business days** before your appointment.
To enter information, click on the gray box. Press "tab" or manually "click" to move to the next gray box. Save answers.

PROFILE:

Child's Name: _____ Gender: ☐ M ☐ F Age: _____

Today's Date: ____/____/____ (mm/dd/yyyy) Date of Birth: ____/____/____ (mm/dd/yyyy)

Parent's Name: _____

Address: _____

Telephone: (Home) ____-____-____ (Cell) ____-____-____ (Work) ____-____-____

Prefer Email Correspondence? ☐ Y ☐ N Email: _____

Parent's Occupation: _____ Employer: _____

Marital status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Child's Siblings / Ages: _____

How did you hear about us? _____

May we give you appointment reminder calls? ☐ Y ☐ N (phone) ____-____-____

May we leave you phone messages? ☐ Y ☐ N (phone) ____-____-____ ☐ same as above

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Telephone: (home) ____-____-____ (cell) ____-____-____ (work) ____-____-____

MEDICAL CONTACTS:

Name of Medical Doctor / Family Physician: _____

Telephone: ____-____-____

Date of last blood work: _____ Date of last annual / physical exam: _____

List any other health care providers (name, specialty, telephone): _____

MEDICAL HISTORY:

List child's health concerns in order of importance:

1. _____

2. _____

3. _____

4. _____

5. _____

Has any health concern recently changed or become worse? ☐ Y ☐ N

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

What has your doctor (currently & previously) diagnosed your child with? _____

Please list all current medications (prescription or over-the-counter) and supplements (herbs, vitamins)

Name of Drug / Supplement	Used For	Date Started	Dose / Frequency
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____
_____	_____	____/____/____	_____

List past prescription medications: _____

List any known allergies (include drugs, food, environmental, chemical and etc.) and the reaction(s) from them.

Has your child undergone any type of allergy and/or food sensitivity testing? ☐ Y ☐ N

If yes, what kind of testing and the results: _____

Child's Present Weight: _____

Child's Weight 1 year ago: _____

Child's Present Height: _____

PRE-NATAL HEALTH:

What was the parent's health at conception? (*sperm joining egg*)

Mother: ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Other: _____

Father: ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Other: _____

Mother's age at child's birth: _____

Did the mother receive pre-natal medical care? ☐ Y ☐ N

Mother's first pregnancy: ☐ Y ☐ N

Mother's health during pregnancy: ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Other: _____

Did the mother experience any of the following during pregnancy:

☐ Bleeding ☐ Diabetes ☐ Nausea ☐ Vomiting ☐ High blood pressure ☐ Thyroid issues

☐ Physical or Emotional trauma ☐ Other: _____

Did the mother use any of the following during pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational drugs ☐ Antibiotics ☐ Other: _____

BIRTH HISTORY:

Term length: ☐ Full ☐ Premature _____ weeks ☐ Late _____ weeks

Birth weight: _____ Birth Length: _____

Method of delivery: ☐ Vaginal ☐ C-section ☐ Induced ☐ Forceps ☐ Anesthesia used

List any complications during labor: _____

Did the child experience any of the following at/or shortly after birth:

☐ Jaundice ☐ Rashes ☐ Seizures ☐ Other: _____

List any traumas (mental, emotional, physical), injury, illness, surgery or hospitalizations:

Incident	Date	Long-term effects
_____	____/____/____	_____
_____	____/____/____	_____
_____	____/____/____	_____

Note when and why your child has had any of the following:

X-Rays:	____/____/____ _____	MRI:	____/____/____ _____
Ultrasounds:	____/____/____ _____	CAT Scans:	____/____/____ _____
Tuberculosis Test:	____/____/____ _____	Last Dental Work:	____/____/____ _____
HIV Test:	____/____/____ _____	Last Eye Exam:	____/____/____ _____

CHILDHOOD ILLNESSES: (check all that apply)

- | | | | | |
|---|---|------------------------------------|----------------------------------|---|
| ☐ Chicken pox | ☐ Measles | ☐ Mumps | ☐ Rubella | ☐ Rheumatic fever |
| ☐ Scarlet fever | ☐ Tuberculosis | ☐ Pertussis | ☐ Asthma | ☐ Seasonal Allergies |
| ☐ Ear Infections | Total Ear Infections (in 1 year): _____ | | | |
| ☐ Colds | Total Colds (in 1 year): _____ | | | |
| ☐ Strep Throat | Total Strep Throats (in 1 year): _____ | | | |
| ☐ Other: _____ | | | | |

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

For what condition(s)? _____

Has your child ever used probiotics after antibiotic use? ☐ Y ☐ N

VACCINATIONS: (check all that apply)

- | | | | |
|---|---|--|--|
| ☐ DPT (diphtheria, pertussis, tetanus) | ☐ HIB (haemophilus influenzae B) | ☐ Small pox | ☐ Varicella (chicken pox) |
| ☐ MMR (measles, mumps, rubella) | ☐ Polio | ☐ Gardasil (HPV) | ☐ Hepatitis A |
| ☐ Hepatitis B | ☐ Seasonal Flu shot | ☐ Tetanus Booster | ☐ Unknown |

Adverse reactions to any vaccines: ☐ Y ☐ N / Explain if marked yes, _____

FAMILY HISTORY:

Please indicate if your child's immediate family has had any of the following conditions:

Condition	Family Member(s)	Condition	Family Member(s)
Alcoholism / Drug abuse		Epilepsy	
Allergies / Hayfever		Heart disease	
Arthritis		High blood pressure	
Asthma / Emphysema		Kidney disease	
Auto-immune disease		Liver disease	
Bleeding disorder		Mental illness	
Cancer		Overweight / Obesity	
Diabetes		Stroke	
Digestive disorder		Thyroid problems	
Eating disorder		Other:	

☐ Don't know child's family medical history (*please explain why*) _____

DEVELOPMENT / DIET / DIGESTION / LIFESTYLE / ENVIRONMENTAL:

At what age did your child first: Sit up: _____ Crawl: _____ Walk: _____ Talk: _____

How many hours does your child sleep nightly? _____

Is your child: ☐ At home ☐ In daycare ☐ In school and Grade: ☐ Other: _____

How would you describe your child's temperament? _____

How would you describe your child's energy? _____

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

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

What are your child's favorite activities? _____

How much television does your child watch? (hours a day/week) _____

Does your child exercise regularly? ☐ Y ☐ N Type: _____

How is/was your child fed? ☐ Breastfed and Duration: _____ ☐ Formula and Type: _____ ☐ Other: _____

Has your child ever experienced colic? ☐ Mild ☐ Moderate ☐ Severe

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

What foods were introduced between 6 and 12 months of age: _____

List any food allergies / sensitivities: _____

Child exposed to environmental pollutants? ☐ Y ☐ N ☐ Unknown

Child exposed to tobacco smoke? ☐ Y ☐ N ☐ Unknown

Child frequently exposed to animals? ☐ Y ☐ N ☐ Unknown

(Y = current / N = never / P = past)

Nightmares? ☐ Y ☐ N ☐ P

Sleepwalk? ☐ Y ☐ N ☐ P

Wake Refreshed? ☐ Y ☐ N ☐ P

Must nap during the day? ☐ Y ☐ N ☐ P

Grind teeth? ☐ Y ☐ N ☐ P

Snore? ☐ Y ☐ N ☐ P

Please record your child's diet for the last 3 days:

	Day 1	Day 2	Day 3
Breakfast			
Lunch			
Dinner			

Does your child have dietary restrictions (religious, vegetarian, vegan)? ☐ Y ☐ N

How many ounces of water does your child drink per day? _____ What type of water? _____

How often are your child's bowel movements? _____

Do they tend towards? ☐ Constipation ☐ Diarrhea ☐ Both ☐ Other: _____

What is the color of the stool? _____ Any undigested food in stool? ☐ Y ☐ N

What is the shape of the stool? ☐ Well-formed ☐ Ribbon-like ☐ Pellets ☐ Other: _____

History of bed-wetting? ☐ Yes ☐ No

History of sexual, mental/emotional or physical abuse? ☐ Y ☐ N

If so, at what age and by whom? _____

What is your child's greatest health concern? _____

How does it limit them the most? _____

How committed are you & your child towards making valuable changes? ☐ Little ☐ Moderate ☐ Very ☐ Don't Know

REVIEW OF SYMPTOMS:

(Y = current / N never / P = past) (Check all that apply)

SKIN								
Rash:	☐ Y	☐ N	☐ P		Color change:	☐ Y	☐ N	☐ P
Hives:	☐ Y	☐ N	☐ P		Lump:	☐ Y	☐ N	☐ P
Psoriasis / eczema	☐ Y	☐ N	☐ P		Itchy:	☐ Y	☐ N	☐ P
Dry:	☐ Y	☐ N	☐ P		Warts / moles:	☐ Y	☐ N	☐ P
Cancer:	☐ Y	☐ N	☐ P		Perspiration	☐ Y	☐ N	☐ P
HEAD								
Headache:	☐ Y	☐ N	☐ P		Migraine:	☐ Y	☐ N	☐ P
Dandruff:	☐ Y	☐ N	☐ P		Head injury:	☐ Y	☐ N	☐ P
Oily / dry hair:	☐ Y	☐ N	☐ P		Hair loss:	☐ Y	☐ N	☐ P
NOSE								
Frequent Colds:	☐ Y	☐ N	☐ P		Nosebleeds:	☐ Y	☐ N	☐ P
Congestion:	☐ Y	☐ N	☐ P		Post nasal drip:	☐ Y	☐ N	☐ P

Polyps:	☐ Y	☐ N	☐ P		Seasonal Allergies:	☐ Y	☐ N	☐ P
EYES								
Dry / Watery:	☐ Y	☐ N	☐ P		Blurry Vision:	☐ Y	☐ N	☐ P
Double Vision:	☐ Y	☐ N	☐ P		Cataracts:	☐ Y	☐ N	☐ P
Glaucoma:	☐ Y	☐ N	☐ P		Styes:	☐ Y	☐ N	☐ P
Strain:	☐ Y	☐ N	☐ P		Discharge:	☐ Y	☐ N	☐ P
Itchy:	☐ Y	☐ N	☐ P		Dark under eyelid	☐ Y	☐ N	☐ P
MOUTH / THROAT								
Canker sores:	☐ Y	☐ N	☐ P		Cold sores:	☐ Y	☐ N	☐ P
Sore throat:	☐ Y	☐ N	☐ P		Gum disease:	☐ Y	☐ N	☐ P
Dentures:	☐ Y	☐ N	☐ P		Cavities:	☐ Y	☐ N	☐ P
Loss of tastes:	☐ Y	☐ N	☐ P		Hoarseness:	☐ Y	☐ N	☐ P
NECK								
Stiffness:	☐ Y	☐ N	☐ P		Swollen glands:	☐ Y	☐ N	☐ P
Full movement:	☐ Y	☐ N	☐ P		Tension:	☐ Y	☐ N	☐ P
RESPIRATORY								
Cough:	☐ Y	☐ N	☐ P		TB:	☐ Y	☐ N	☐ P
Shortness of breath w/ exertion:	☐ Y	☐ N	☐ P		Bronchitis	☐ Y	☐ N	☐ P
Shortness of breath sitting:	☐ Y	☐ N	☐ P		Pneumonia:	☐ Y	☐ N	☐ P
Shortness of breath lying down:	☐ Y	☐ N	☐ P		Asthma	☐ Y	☐ N	☐ P
Wheezing:	☐ Y	☐ N	☐ P		Painful breathing	☐ Y	☐ N	☐ P
CARDIOVASCULAR								

High Blood Pressure:	☐ Y	☐ N	☐ P		Rheumatic Fever	☐ Y	☐ N	☐ P
Low Blood Pressure:	☐ Y	☐ N	☐ P		Murmurs	☐ Y	☐ N	☐ P
Arrhythmias:	☐ Y	☐ N	☐ P		Palpitations:	☐ Y	☐ N	☐ P
Edema:	☐ Y	☐ N	☐ P		Chest pain:	☐ Y	☐ N	☐ P
URINARY TRACT								
Incontinence:	☐ Y	☐ N	☐ P		Pain w/ urination	☐ Y	☐ N	☐ P
Frequent Infections:	☐ Y	☐ N	☐ P		Kidney Stones	☐ Y	☐ N	☐ P
Urgency	☐ Y	☐ N	☐ P		Discharge / blood	☐ Y	☐ N	☐ P
GASTROINTESTINAL								
Heartburn:	☐ Y	☐ N	☐ P		Parasites	☐ Y	☐ N	☐ P
Indigestion:	☐ Y	☐ N	☐ P		Blood in stool	☐ Y	☐ N	☐ P
Bloating:	☐ Y	☐ N	☐ P		Diarrhea	☐ Y	☐ N	☐ P
Nausea:	☐ Y	☐ N	☐ P		Constipation	☐ Y	☐ N	☐ P
Vomiting:	☐ Y	☐ N	☐ P		Liver disease:	☐ Y	☐ N	☐ P
Change in appetite:	☐ Y	☐ N	☐ P		Gall bladder disease	☐ Y	☐ N	☐ P
Pancreatitis:	☐ Y	☐ N	☐ P		Ulcer	☐ Y	☐ N	☐ P
MUSKULOSKELETAL								
Weakness:	☐ Y	☐ N	☐ P		Arthritis:	☐ Y	☐ N	☐ P
Stiffness:	☐ Y	☐ N	☐ P		Leg cramps:	☐ Y	☐ N	☐ P
Tremors:	☐ Y	☐ N	☐ P		Growing Pains:	☐ Y	☐ N	☐ P
NERVOUS SYSTEM								
Paralysis:	☐ Y	☐ N	☐ P		Sciatica:	☐ Y	☐ N	☐ P
Tingling / numbness:	☐ Y	☐ N	☐ P		Carpal tunnel:	☐ Y	☐ N	☐ P
Seizures:	☐ Y	☐ N	☐ P		Fainting:	☐ Y	☐ N	☐ P

MENTAL / EMOTIONAL								
Depression:	☐ Y	☐ N	☐ P		Anger / Irritability	☐ Y	☐ N	☐ P
Suicidal:	☐ Y	☐ N	☐ P		High strung/ tense	☐ Y	☐ N	☐ P
Anxiety	☐ Y	☐ N	☐ P		Fear / Panic:	☐ Y	☐ N	☐ P
Eating disorder:	☐ Y	☐ N	☐ P		Speech Impediment	☐ Y	☐ N	☐ P
PTSD	☐ Y	☐ N	☐ P		Learning Impediment	☐ Y	☐ N	☐ P

What potential obstacles do you foresee in addressing the lifestyle factors, which are undermining your child's health, and in adhering to the therapeutic protocols?

What are your goals and expectations after your child's first new patient visit

Is there any other information that you feel is important that has not been covered?

**Thank you very much for taking the time to complete this thorough form.
It will greatly assist in the formulation of an individualized protocol specific to your healthcare needs**