CHILD INTAKE FORM

Name: ______________________________________Age: ____ Birth Date: _______________ Sex: *M / F*

Address: ____

Parents E-mail: _______________________________Cell : [_] _________________ Work:[_] ________________

Telephone: (home) [_] ____________________

Parents Names: Mother - ____________________________ Age - _____ Occupation - _____________________

Father - ____ Age - _____ Occupation - ____________________

Whom does the child live with? ______________________ Name of Medical Doctor: _____________________

Ethnic Background: _______________________________

Has your child been treated by an herbalist or naturopathic doctor before? *Y or N*

If 'yes', by whom? ______________________________________ When? ____________________________

For what reason(s)? ____

Parent/Guardian Signature: ____________________________ Date: ________________

List your child's health concerns and how long they have been occurring, in order of importance:

1.____

2.____

3.____

4.____

5.____

6.____

CONFIDENTIAL HEALTH QUESTIONNAIRE

Dear Parent/Guardian: Please complete your child's questionnaire with care. Successful health care and wellness optimization are only possible when the provider has a complete understanding of the client physically, mentally, and emotionally. This is a confidential record of your child's medical history. It will not be released without your prior authorization.

Has your child had similar health concerns before?
Explain:

Does your child have any relatives with similar problems?

When did your child last feel well?

What long-term expectations do you as a parent have from working with this clinic?

What expectations do you have of me personally as your herbalist?

What behaviors or lifestyle habits does your child currently engage in regularly that you believe support his/her health? Please list.

What behaviors or lifestyle habits does your child currently engage in regularly that you believe are self-destructive to their health? Please list.

What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your child's health and in adhering to the therapeutic protocols that I will be sharing with you?

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes your child will be making?

What is your present level of commitment to address any underlying causes of your child's health concerns that relate to your nutrition and/or lifestyle? Rate on a scale from 1 to 10, with 10 indicating 100% commitment.

(0%) 0 1 2 3 4 5 6 7 8 9 10 (100%)

MEDICATIONS

How many times has your child been treated with antibiotics?___________ When was the last time?________

Main reason for antibiotic use: ☐ Ear Infections ☐ Bronchitis ☐ Pneumonia ☐ Sinus Infection ☐ Intestinal Infection ☐ Other (please explain)________________________

Was your child ever treated for a yeast infection following antibiotic use? ________________________________

Please list all **"current"** prescription medications

Medication	Date started [m/y]	Dose	Effectiveness

Please list all **"past"** prescription medications

Medication	Date started [m/y]	Dose	Effectiveness

Please list all **"current"** vitamins, herbs, homeopathics, non-prescription, etc

Supplement / Vitamin (Brand Name)	Date started [m/y]	Dose	Effectiveness

Please list all **"past"** vitamins, herbs, homeopathics, non-prescription, etc

Supplement / Vitamin (Brand Name)	Date started [m/y]	Dose	Effectiveness

FAMILY HISTORY

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

Condition	Relative(s)	Condition	Relative(s)	Condition	Relative(s)
□ Alcoholism		□ Depression		□ Learning disabilities	
□ Allergies		□ Diabetes		□ Mental Illness	
□ Anemia		□ Eczema		□ Multiple sclerosis	
□ Arthritis		□ Epilepsy		□ Muscular dystrophy	
□ Asthma		□ Glaucoma		□ Seizures	
□ Bed wetting		□ Heart disease		□ Stomach ulcers	
□ Birth defects		□ Hay Fever		□ Stroke	
□ Bleeding disorder		□ High Blood Pressure		□ Tuberculosis	
□ Cancer		□ Hyperactivity		□ Yeast infection	
□ Celiac disease		□ Juvenile Arthritis		□ Venereal disease	
□ Colitis		□ Kidney Disease		□ Other:____________	

☐ I don't know the family medical history ☐ This child is adopted

Please fill in the following chart, based on the child's relatives:

Relation	Age (if living)	If deceased, at what age & cause of death?
Mother		
Father		
Sibling(s)		
Sibling(s)		
Sibling(s)		
Sibling(s)		
Sibling(s)		
Maternal grandmother		
Maternal grandfather		
Paternal grandmother		
Paternal grandfather		

Do either of the parents have a chronic illness? *Y / N* If yes, please describe.

CHILD'S HEALTH HISTORY

Does your child have any known contagious diseases at this time? *Y / N* If yes, what?__________________

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

Please indicate any serious conditions, illnesses, injuries, surgeries, and/or hospitalizations that your child has had. Include approximate dates.

List any X-rays, CT scans, or other studies that your child has had.

Significant physical or emotional trauma:

Allergies:

Any chemical or environmental allergies?

Any allergies to supplements / drugs / herbs / foods?

Childhood Conditions: (check those that apply) Which of the following conditions has your child had?

- ◯ Asthma/Wheezing
- ◯ Bedwetting
- ◯ Behavior problems
- ◯ Bladder infections
- ◯ Body/breath odor
- ◯ Bronchitis
- ◯ Burning of urine
- ◯ Canker sores
- ◯ Change in appetite
- ◯ Chicken pox
- ◯ Cold intolerance
- ◯ Constipation
- ◯ Cradle cap
- ◯ Cries easily
- ◯ Croup
- ◯ Diarrhea
- ◯ Dizzy spells
- ◯ Ear infections
- ◯ Easy bleeding
- ◯ Easy bruising
- ◯ Eczema
- ◯ Eye infections / styes
- ◯ Fatigue
- ◯ Fractures
- ◯ Frequent colds
- ◯ Frequent urination
- ◯ Fungal infections
- ◯ Gas (excessive)
- ◯ Growing pains
- ◯ Hair loss
- ◯ Hearing problems
- ◯ Heart disease
- ◯ Heat intolerance
- ◯ High fevers
- ◯ Learning difficulties
- ◯ Lice
- ◯ Measles
- ◯ Meningitis
- ◯ Molluscum contagiosum
- ◯ Mumps
- ◯ Nervousness
- ◯ Night sweats
- ◯ Nose bleeds
- ◯ Pneumonia
- ◯ Physical trauma
- ◯ Rubella
- ◯ Seizures
- ◯ Sleep apnea/snoring
- ◯ Stomach aches
- ◯ Strep throat
- ◯ Tonsillitis
- ◯ Unusual fears
- ◯ Vision problems
- ◯ Whooping cough
- ◯ Other:

Is there any condition from which you feel your child has **never been well since**?

Immunizations: What immunizations has your child had?

◯ DPT (diphtheria, pertussis, tetanus)
◯ Hepatitis A
◯ Flu shot
◯ Haemophilus influenza B
◯ Hepatitis B
◯ Polio
◯ MMR (measles, mumps, rubella)
◯ Hepatitis C
◯ Smallpox
◯ Chicken pox
◯ SARS-CoV-2 (Covid)
◯ Other:

Please indicate any adverse reactions your child has experienced from an immunization.

◯ Fever
◯ Excessive crying
◯ Pain/swelling
◯ Behavior changes
◯ Joint pain
◯ Limping
◯ Mood changes
◯ Rash
◯ Loss of appetite
◯ Vomiting
◯ Insomnia
◯ Other:

Prenatal Health and History:

What age was mother at child's conception? _______ Father's age at conception? _________

Parents' health at conception (E = excellent, G = Good, P = Poor)

Mother: ______ Father: _____

Was your child conceived naturally? Y / N

Was there any difficulty conceiving this child? Y / N

Any fertility interventions? Y / N If yes, explain:

On a scale of 1 - 10 (10 being highest), while pregnant, please rate your stress_____ & energy levels____ .

Any new events/changes/symptoms/conditions in your life that occurred during pregnancy? *Y / N*

How many previous pregnancies _________and births________?

Did the mother experience any of the following during pregnancy?

◯ Bleeding
◯ High blood pressure
◯ Nausea
◯ Vomiting
◯ Gestational Diabetes
◯ Preeclampsia
◯ Emotional trauma
◯ Physical trauma
◯ Thyroid problems
◯ Rubella
◯ Sexually transmitted infection
◯ Depression/anxiety
◯ Forced bed rest
◯ Other:__________________

Did the mother use any of the following during pregnancy?

◯ Tobacco
◯ Alcohol
◯ Recreational drugs:
◯ Prescription medications (incl antibiotics):
◯ Over-the-counter medications:
◯ Vitamins and/or supplements:
◯ Coffee: *Y / N* ____cups/d
◯ Soft drinks: *Y / N* __________cups/d
◯ Artificial sweeteners: *Y / N*

Birth History: (please complete if your child is less than 2 years old)

Term length: ☐ Pre-term (37 weeks or less): _________ weeks ☐ Full-term (38-42 weeks): _________ weeks
☐ Post-term (more than 42 weeks): __________ weeks

Location of birth: ☐ Hospital ☐ Home ☐ Birthing Center ☐ Midwife ☐ Other:____________

Types of Intervention: ☐ Induction ☐ Forceps ☐ Epidural/anesthesia ☐ Episiotomy
☐ Vacuum extraction ☐ Cesarean section ☐ Other:

Length of labor: ______________ Weight of infant at birth:__________ Length of infant at birth:___________

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

- ◯ Anemia
- ◯ Bradycardia
- ◯ Cyanosis
- ◯ Congenital defects:
- ◯ Jaundice
- ◯ Rashes
- ◯ Seizures
- ◯ Birth injuries:
- ◯ Infections:
- ◯ Breathing difficulty:
- ◯ Difficulties with feeding:
- ◯ Colic: *mild / moderate / severe*
- ◯ Birth defects:
- ◯ Atrioventricular septal defect:
- ◯ Other:

How was the mother's physical and emotional health during postpartum/recovery?

Please write any details pertaining to the birth experience that you feel are important to their well-being:

Feeding History:

☐ Breast ☐ Bottle What kind of formula?

How long for either?

Did your infant experience any reactions to formula or breast milk?
Any difficulties with breast or bottle feeding (ie. Tongue or lip tie, sucking difficulties, etc.)?

Please list any foods that were introduced before 6 months, as well as any reactions noted:

What foods were introduced between 6 and 12 months? Were there any reactions to these foods?

Does your child have any food cravings or aversions?

Please describe your child's eating habits (e.g., good appetite, picky eater, etc.).

Digestive Health:

Does child have periodic loose stools/diarrhea? *Y / N*

Offensive Gas? *Y / N*

Undigested food in stool? *Y / N*

Is your child potty trained? *Y / N*

Does your child suffer with reflux/heartburn? *Y / N*

Bloating after eating? *Y / N*

Does your child produce formed stools? *Y / N* Number of bowel movements per day: ________

Is your child currently taking an acid-blocking medication such as Losec, Pepcid, etc? *Y / N*

Did occurrence of digestive problems occur following a particular vaccine? *Y / N / Unsure*

Diet: Describe a typical day's diet.

Breakfast____

Lunch____

Supper____

Snacks____

How many cups/bottles/glasses does your child drink on average per day?

Beverage	Amount	Beverage	Amount	Beverage	Amount
Water		Fruit juice		Soft drinks, regular	
Milk		Vegetable juice		Soft drinks, diet	
Soy milk		Herbal Tea		Caffeine/energy drinks	

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

Developmental Milestones:

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

How is your child's health now? *Poor Fair Good Excellent Unknown*

At what age did your child first: Sit up______ Crawl______ Walk______ Talk ______

At what age did your child begin teething? ________ Were there any difficulties associated with it?

Sleep Patterns:

What time does your child usually go to bed?_________ wake in the morning?_______

How many times does your child wake during the night? ______

Does your child nap? *Y / N* Length of nap: ___________ Does your child wake rested? *Y / N*

Does your child have nightmares? *Y / N*

Does your child have any problems associated with sleeping (e.g., trouble falling asleep, trouble waking up, bed wetting, etc.)?

Does your child snore? Y / N If yes, are they a daytime mouth-breather? Y / N

Social History:
How would you describe your child's temperament/personality?

What are your child's interests and favorite activities? What recreational activities is your child involved in?

Are the parents currently together? *Y / N*
Number of siblings (where does this child fall in birth order): ______________________________________

Is your child in: ☐ school ☐ daycare ☐ home care ☐ other:______________________________

How does your child interact with others?

How does your child handle stress?

Does your child have any unusual habits?

Does your child exercise regularly? *Y / N* Type, duration, frequency?____________________________

How much screen time does your child partake in? _____ hours a day/week

Home Environment:
Are there any pets in the home? *Y / N* What type and how many?____________________________

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

Age of home:

Flooring type (ie. Carpet, laminate, vinyl, tile, etc. and age of flooring):

How is the child's home heated? Forced air / wood stove / radiators / other:

Lead paint (old home, age):__________ Is home located near a power line and/or cell phone tower? *Y / N*

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

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

Does your child have any known environmental or chemical sensitivities (e.g., perfumes, detergents, odors, soaps, etc.)?

General Info:

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

Thank you for taking the time to complete this detailed questionnaire. This information is kept confidential and will be a valuable resource as we work together to optimize your child's health.