Child Intake

I appreciate the time you take to fill in this form, if provides me with an accurate history of you and your child. If there is any information you are not comfortable providing please do not or if there is something you would like to add please add it. Thank you.

Child's Name:_____ Today's Date_____

Child's Age: _____Child's Ethnicity:_____ Sex: M F

Date of Birth:_____ /_____ /_____ (*month/day/year*)

Height of Child: _____ Weight of Child: _____ Grade Level: _____

Your Name: _____ Relation_____

Who does the child live with?_____

Primary Contact_____ Relation_____

Home phone_____ Other Phone_____

Address_____

Contact #2_____ Relation_____

Home phone_____ Other phone_____

Address_____

The Child's Health Care Providers (phone # and/or address please)

1. _____
2. _____
3. _____

Please List the Child's Health Concerns in order of importance

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

Birth History

49 Bridge St. E, Campbellford, ON, K0L 1L0
t.705.632.1112 e. info@andreabullnd.ca
www.trenthillshealth.com

Term Length: □ Pre-term (37 weeks or less): _____weeks
□ Full-term (38 → 42 weeks): _____weeks
□ Post-term (more than 42 weeks): _____weeks
Up to what time did the mother work prior to delivery?

_____

Location of Birth: □ Hospital □ Home □ Birthing Center
□Other:_____

Name of delivery doctor, midwife, doula, other:

_____

Type of Birth: Vaginal (□ Head First, □ Breech) □ C-section

Were there any complications during delivery (vacuum, forceps, other)?

_____

Were any medications administered during labor (oxytocin, streptomycin, other)?

_____

Length of Labor: _____Weight and Length of Infant at Birth: _____

Did the infant experience any of the following at or shortly after birth (please elaborate where necessary)?

□ Jaundice □ Respiratory Difficulties □ Failure to Thrive □ Rashes

□ Seizures □ Birth Injuries □ Birth Defects □ Other:

_____

_____

Mother's History

1. How was the health of the parents at the <u>time of conception</u> (please circle)?

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

2. How old was the mother at conception? _____Father?_____
3. Were any fertility drugs (etc…) used prior to conception? Explain.

_____

_____

4. How was the mother's <u>health during</u> the pregnancy?
   Poor Fair Good Excellent Unknown

5. Did the mother receive prenatal medical care? Yes No Unknown
6. Did the mother receive Naturopathic prenatal care? Yes No
7. How was the mother's <u>diet during</u> the pregnancy?

   Poor Fair Good Excellent Unknown

8. How many prior pregnancies and live births did the mother have?_____
9. Did the mother use any of the following during pregnancy?

   □ Tobacco □ Alcohol □ Recreational Drugs: _____

Prescription Medications:_____

Over-the-counter Medications:_____

Vitamins / Supplements:_____

10. Were there any complications during the pregnancy (high blood pressure, bleeding, thyroid problems, toxemia, eclampsia, gestational diabetes, bed rest, nausea, vomiting, mental, emotional, physical trauma, other)?
    _____

11. Were any tests performed during pregnancy (ultrasound, amniocentesis, streptococcus swab, other)? What were the findings?
    _____

Lifestyle and Environment

Are the child's parents: □ Married □ Separated □ Divorced □Other:_____

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

Are there any pets in the home? No Yes: _____

Does anyone in the household smoke? No Yes

What cleaning products are used in the home? (Please list)

_____

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

_____

Please chart the stress level in the child's home: (1=least stressful) → (10=most stressful)

1 2 3 4 5 6 7 8 9 10

Is the child in: □ School □ Daycare □ Home care □Other:_____

Child

How many hours of TV per day does the child watch?_____
How many hours of exercise per day does the child get?_____
What are the child's favorite activities?_____
How often does your child read?_____

Mother:

Alcohol: Yes No Drinks per day_____
Cigarette Smoking: Yes No Cigarettes per day_____
Prescription Drugs: Yes No Names and doses_____
Recreational Drugs: Yes No
Supplements: Yes No
Regular Exercise: Yes No
Were these habits consistent throughout pregnancy? Yes No

Diet History

How was the infant fed?
□ Breast-fed, how long? _____ □ Formula? _____
□ Other (Cow's Milk / Soy Milk / Rice Milk): _____

What foods were introduced before 6 months (please list approximate month of introduction)?

_____

What foods were introduced between 6 and 12 months of age (please list approximate month of introduction)?

_____

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

_____

Does your child have any dietary restrictions? (Vegetarian, vegan, religious, etc)?_____

Health and Development
Did your child gain weight appropriately? Explain.
_____

At what age did your child first?

Sit up (w/out assistance):____Crawl:_____ Walk: _____

1st Eruption of teeth:_____Toilet Trained:_____Talk: _____

Describe your child's typical sleep patterns (hrs/night, waking during the night, etc…):
_____
_____

Does your child have any problems associated with sleeping?

□ Trouble falling asleep □ Waking during night □ Recurrent dreams
□ Nightmares □ Night terrors
□ Requires night light to sleep □ Other (please):_____

Does this child have any siblings? If so, how many, age, sex?
_____

Birth order of this child?_____

Please provide as much information as possible on the following childhood illnesses, include the year the illness occurred and the frequency of a recurrence.

Chicken Pox	
Measles	
Mumps	
Ear Infection	

General susceptibility	
Other illnesses	

Comments:_____
_____

Family History (mother, father, grandparents, aunts, uncles, other):
Please indicate if any member of the family has experienced any of the following

Condition	Relative	Condition	Relative
□ Allergies		□ Seizures	
□ Anemia		□ Stroke	
□ Arthritis		□ Diabetes	
□ Birth Defects		□ Eczema	
□ Bleeding Disorder		□ Glaucoma	
□ Cancer		□ Kidney Disease	
□ Hay Fever		□ Psoriasis	
□ High Blood Pressure		□ Depression	
□ Heart Attack/Disease		□ Tuberculosis	
□ Other:		□ Mental Illness (explain):	

□ I don't know the family medical history

Do either of the parents have a chronic illness? Yes No Please describe___
_____

Is there is any other information you would like me to have at this time?_____
_____

Thank you for your time. I look forward to working with you and your child.