



### **Child Intake Form (up to 12 years of age)**

**Due to the chemical sensitivity of some of our patients, we ask that you please refrain from wearing perfume/cologne when visiting our office. Thank you.**

Name \_\_\_\_\_ Date \_\_\_\_\_  
Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Gender: \_\_\_\_\_ Preferred Pronouns: \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Prov \_\_\_\_\_ Postal Code \_\_\_\_\_  
Telephone# (home) \_\_\_\_\_ Parent/Guardian (Work) \_\_\_\_\_  
Name of Parent/Guardian \_\_\_\_\_  
Email of Parent/Guardian \_\_\_\_\_  
*Email address will only be used for correspondence from the Centre for Natural Medicine*  
MHSC (6 digit): \_\_\_\_\_ PHIN (9 digit): \_\_\_\_\_

How did you hear about this clinic? \_\_\_\_\_

#### **PLEASE COMPLETE THE FOLLOWING QUESTIONS**

What are his/her most important health problems that he/she is seeking treatment for or is currently being treated for? List as many as you can, in order of importance.

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

#### **ALLERGIES**

Is he/she hypersensitive or allergic to any of the following (please list):

**Prescription Drugs?** \_\_\_\_\_ **Environmental?** (pollen, dust etc.) \_\_\_\_\_

**Foods?** \_\_\_\_\_

**CURRENT MEDICATIONS**

Please list **any** prescription medications, over the counter medications, vitamins or other supplements he/she is taking:

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**TYPICAL FOOD INTAKE**

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Beverages: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

Frequently Eaten Foods: \_\_\_\_\_

**GENERAL**

Weight: \_\_\_\_\_ lbs      Weight 1 year ago: \_\_\_\_\_ lbs

Max. Weight / When : \_\_\_\_\_      Height: \_\_\_\_\_

When during the day is his/her energy the best? \_\_\_\_\_      Worst? \_\_\_\_\_

## REVIEW OF SYSTEMS

Y = A condition he/she has now

N = A condition he/she never had

P = A condition he/she has had in the past but is not experiencing at this time.

### PLEASE CIRCLE THE APPROPRIATE LETTER FOR THE FOLLOWING:

#### Mental/Emotional

Mood Swings	Y N P	Anxiety or nervousness	Y N P
Poor Concentration	Y N P	Memory Problems	Y N P

#### Endocrine

Hypothyroid	Y N P	Heat or cold intolerance	Y N P
Hypoglycemia	Y N P	Diabetes	Y N P
Fatigue	Y N P	Seasonal Depression	Y N P

#### Immune

Vaccinations	Y N P	Reactions to vaccinations	Y N P
Chronic infections	Y N P	Chronic swollen glands	Y N P
Slow Wound Healing	Y N P	Body odor/Bad breath	Y N P

#### Skin

Rashes	Y N P	Eczema, Hives	Y N P
Acne, Boils	Y N P	Itching	Y N P

#### Head

Headaches	Y N P	Migraines	Y N P
Head Injury	Y N P		

#### Ears

Earaches	Y N P	Impaired Hearing	Y N P
Dizziness	Y N P	Ringing in Ears	Y N P

#### Nose and Sinuses

Frequent colds	Y N P	Nosebleeds	Y N P
Stuffiness	Y N P	Hayfever	Y N P
Sinus Problems	Y N P	Loss of Smell	Y N P

#### Mouth and Throat

Frequent sore throat	Y N P	Sore tongue/lips	Y N P
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		<b><u>Respiratory</u></b>	
Cough	Y N P	Wheezing	Y N P
Asthma	Y N P	Bronchitis	Y N P
		<b><u>Cardiovascular</u></b>	
Heart Disease	Y N P	High/Low Blood Pressure	Y N P
Palpitations	Y N P		

		<b><u>Gastrointestinal</u></b>	
Heartburn	Y N P	Belching or passing gas	Y N P
Change in thirst	Y N P	Change in appetite	Y N P
Constipation	Y N P	Diarrhea	Y N P
How many bowel movements a day? _____ Is this a change? _____			

		<b><u>Urinary</u></b>	
Increased frequency	Y N P	Frequency at night	Y N P
Frequent Infections	Y N P	Genital Redness	Y N P

		<b><u>Musculoskeletal</u></b>	
Joint pain	Y N P	Stiffness in joints	Y N P
Muscle spasms/cramps	Y N P	Arthritis	Y N P

<b>HABITS</b>
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Does he/she exercise? Y N P  
 If yes, what kind and how often?  
 Average 8-10 hrs. sleep Y N P      Sleep well      Y N P      how may hours \_\_\_\_\_  
 Awaken Rested      Y N P      Any Major traumas      Y N P  
 History of abuse      Y N P      Eat refined sugar      Y N P  
 Watch television      Y N P      Read      Y N P  
 How many hours? \_\_\_\_\_

Is there any information about the child's health that you would like to add?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Cancellation Policy:** Scheduled appointments are reserved especially for you. We require **2 full business days** notice for cancellations or rescheduling. Cancellations within 2 business days of the scheduled appointment will incur a fee. **Thank you for your cooperation.**

**Please Print:**

I \_\_\_\_\_, parent/guardian of \_\_\_\_\_ (patient's full name), agree to pay my full account at the time of each visit or treatment, including fees for appointments, services, cost of supplements and remedies, cost of laboratory tests, administrative fees, missed appointment fees, as well as other applicable fees.

By signing below, I am confirming that I have medical decision-making responsibility for this minor.

Date: \_\_\_\_\_ Signature : \_\_\_\_\_