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

Respiratory

Cough	Y N P	Wheezing	Y N P
Asthma	Y N P	Bronchitis	Y N P

Cardiovascular

Heart Disease	Y N P	High/Low Blood Pressure	Y N P
Palpitations	Y N P		

Gastrointestinal

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? _____

Urinary

Increased frequency	Y N P	Frequency at night	Y N P
		Genital Redness	Y N P
Frequent Infections	Y N P		

Musculoskeletal

Joint pain	Y N P	Stiffness in joints	Y N P
Muscle spasms/cramps	Y N P	Arthritis	Y N P

HABITS

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 :_____