



## Child Intake Form

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*I appreciate the time you take to fill in this form, it 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**

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 time of conception (please circle)?

<b>Mother:</b>	Poor	Fair	Good	Excellent	Unknown
<b>Father:</b>	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 health during 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 diet during 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

How is the air quality of the home? Poor Fair Good Excellent Unknown

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: \_\_\_\_\_

1<sup>st</sup> 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
<input type="checkbox"/> Allergies		<input type="checkbox"/> Seizures	
<input type="checkbox"/> Anemia		<input type="checkbox"/> Stroke	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Birth Defects		<input type="checkbox"/> Eczema	
<input type="checkbox"/> Bleeding Disorder		<input type="checkbox"/> Glaucoma	
<input type="checkbox"/> Cancer		<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Psoriasis	
<input type="checkbox"/> High Blood Pressure		<input type="checkbox"/> Depression	
<input type="checkbox"/> Heart Attack/Disease		<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Other:		<input type="checkbox"/> 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.**