Shahram Ayoubzadeh M.D.(Senegal), N.D.
Julie Goldring, B.P.E., N.D.

CHILD INTAKE FORM

Confidential

Please complete this form about the health of your child.

Child's Name: _____ Date:_____
Age of child:_____ Date of birth d/m/y: _____ Gender: M F

Contact Information

Name of Parent(s)/Guardian(s): _____
Address: _____
_____
_____
Preferred phone number for contact: _____
Email: _____
Person to be contacted in Case of Emergency: _____ Relationship: _____
Please indicate if the emergency contact information is different than above:
_____
_____
Child's Primary Care Physician/Pediatrician: _____
Other Health Care Providers:_____
_____
_____
Other health care regimes the child is currently following:_____
_____
_____

Health Concerns

Please briefly outline the child's health concerns (in order of importance):
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Medical History

Childhood illnesses: please indicate which illness(es) or condition(s) your child has had by using a **N** if (s)he has the condition now, **P** if (s)he had it in the past and **B** for both now and in the past

___Measles	___Herpes	___Frequent Infections
___Mumps	___Bed Wetting	___Anxiety
___Strep Throat	___Indigestion/Gas	___Influenza
___Chicken Pox	___Mononucleosis	___Frequent Runny Nose
___Cough	___Headaches	___Dizziness
___Wheezing	___Pneumonia	___Colitis
___Hives/Rashes	___Recurrent Ear Infections	___Scarlet Fever
___Diarrhea	___Jaundice	___Bladder Infection
___Constipation	___Colic or irritability	___Rubella (German Measles)
___Whooping cough	___Eczema	___Insect hypersensitivity
___Impetigo	___Abdominal pain	___Diarrhea
___Anal itching	___Excess thirst	___Itchy scalp
___Dark Urine/Blood in Urine	___Seizures	___Fainting
___Aching joints or muscles		

Please list any complications that resulted from any of the above illnesses:_____
_____
Does the child suffer from any serious or chronic illness? _____
_____

Please indicate any injuries, hospitalizations or surgeries (please add dates, reasons, and complications):
_____
_____
_____
_____

How many times a year does the child suffer from the following?:
Ear Infections:_____ Strep Throat:_____ Colds:_____

Does the child have any allergies (medications, supplements, contact agents, foods, environment, etc.)?:_____
_____
_____

Vaccinations (please check)

Vaccination	✓	**Age received**	**Reaction to vaccine?**
Hepatitis B (HBV)	_____	_____	_____
Measles/Mumps/Rubella (MMR)	_____	_____	_____
Injected/Oral Polio (IPV/OPV/TOPV)	_____	_____	_____
Diptheria/Tetanus/Pertussis (DTP)	_____	_____	_____
Chicken Pox (Varivax)	_____	_____	_____
Haemophilus influenza B (HiB/HbCV)	_____	_____	_____
Pneumococcal	_____	_____	_____
Flu shot	_____	_____	_____
Meningitis	_____	_____	_____
Prevnar (pneumonia)	_____	_____	_____
Other:	_____	_____	_____

Medications
Please indicate which medication(s) the child is now using or has used in the past:

	now	past	frequency	types used/notes
Pain/Fever Medication	____	____	_____	_____
Antibiotics (include approx. # of rounds)	____	____	_____	_____
Decongestants	____	____	_____	_____
Other _____	____	____	_____	_____
_____	____	____	_____	_____

Please list all vitamins, herbs, homeopathic, or other supplements currently being taken (or has been taken with some frequency in the past): _____
_____
_____
_____

Prenatal History

Were there any genetic concerns before/during pregnancy?: Y/N _____
How would you describe the health of the parents at conception?: _____
_____
_____

How would you describe the health of the mom during pregnancy (physical/emotional stress)?: ____
_____
_____
Did the mother suffer any traumas during pregnancy?: _____
_____
Was there an excess intake of any certain food during pregnancy? _____
_____
_____
Please list exposure to any of the following substances during pregnancy - drugs, alcohol, smoke, second-hand smoke: _____
Please list the supplements and/or medications the mother was taking during pregnancy:_____
_____
_____
_____

Labour and Delivery

Was the birth pre-term or post-date pregnancy? _____
Were there any complications of labour (placenta previa, breech, hypotension, etc.)? _____
_____
Type of delivery (vaginal, caesarean; breech, vertex): _____Was an epidural used?: Y/N
Was there any need for resuscitation of the child? Y/N
Was the baby discharged with the mother? Y/N
Did the child experience any of the following at or shortly after birth?
___Jaundice ___Rashes ___Seizures ___Birth Injuries
___Other: _____

Developmental History

Have there been any developmental delays? _____
Have there been any periods of rapid weight gain or weight loss? _____
_____

Milestone	Age	Milestone	Age
Supports self in standing position	_____	Toilet trained	_____
Weaned off breast milk	_____	Ties shoes	_____
First Tooth	_____	Dresses without help	_____
Crawls	_____	Hits Puberty	_____
First word (besides mama, dada)	_____	First menstruation	_____
Walks	_____		_____

Nutrition and Lifestyle

Was/is the child breastfed? Y/N For how long? _____
Was the child fed formula? Y/N Type (milk, soy, other): _____
At what age was the formula was introduced?: _____
Were/is there any feeding difficulties? _____
Did the child ever have any difficulty gaining weight? Y/N

What foods were introduced before 6 months? _____
_____
What foods were introduced between 6-12 months? _____
_____
_____
Did the child react to any of the new foods introduced?_____
_____
Are there any nutritional restrictions (due to ethnicity, ethics, religion, etc.)? _____
_____
If applicable, please indicate the child's frequency and intake of the following substances:
Pop:_____ Water:_____ Caffeine (incl. Chocolate)_____

Typical diet:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages:_____

What is the sleeping pattern of the child? Are there any difficulties sleeping?_____
_____

How regularly does the child get exercise?_____
_____

Are there any toxins or other hazards to which the child is regularly exposed?_____
_____

Family Health History
Please indicate the conditions the child's family members (immediate or otherwise) have experienced.

Condition	Relation	Condition	Relation
Allergies		Liver disease	
Anxiety		Lung disease	
Arthritis		Nervous system disorder	
Asthma		Pneumonia	
Cancer		Skin disease	
Depression		Stroke	
Diabetes		Substance abuse	
Epilepsy		Syphilis	
Gonorrhea		Tuberculosis	
Gout		Other:	
Heart disease			
High Blood Pressure			
Inflammatory Bowel Disease			
Kidney disease			

Social History

Day care/school grade of the child: _____
Has the child been assessed or diagnosed with any learning disabilities?_____
_____
How would you describe the child's performance at school?:_____
_____
Please comment on the child's behaviour and personal experience at school (has it been positive, negative): _____
_____
Does the child have any notable fears, anxieties, or worries? _____
_____

Home Environment

Marital status of parents: _____
How many siblings are there at home? _____
How would you describe the emotional climate of the child's home? Is there any stress in the household? _____
_____
Is the child exposed to smoke?: Y/N
Are there pets in the household?: Y/N Type(s):_____
How is the home heated? _____

Travel History

Has the child ever travelled abroad to any other countries? To where and for how long? _____
_____
_____
Did the child suffer from any illnesses during or immediately after? _____
_____

If there is anything else you would like to add that has not already been covered, please outline it below:

_____
_____
_____
_____
_____