131 Union Street East,
Suite #103
Waterloo, ON
N2J 1C4

The Natural Way
HEALTH CLINIC
where healing begins

(T) 519-772-2116
(F) 866-731-5603
www.thenaturalwayclinic.com

CHILD INTAKE FORM

(Child up to the age of 18)

Please take a few minutes to complete this form to the best of your ability. The information provided in this form will help to provide me with a general overview of your child's health on a physical, mental, and emotional level, and assist me in preparing a treatment plan that will best meet their individual health needs and goals.

Full Name: _____ Date: _____

Date of Birth: _____ (m/d/y) Age: _____ Sex: Male / Female/ Other

Who is filling out this form? (Name & Relation): _____

☐ **I give my consent to include my e-mail address on the clinic newsletter mailing list**

How did you hear about The Natural Way/ Who may we thank?

☐ Google ☐ Facebook ☐ Instagram

☐ Educational Talk ☐ Newsletter ☐ Yellow Pages

☐ External Practitioner: ☐ Patient Referral: ☐ The Natural Way Staff: ☐ Other: _____

_____ _____ _____

Parent/Guardian's Contact Information:

Name: _____ Relationship: _____
Mailing Address: _____
City: _____ Postal Code: _____
Telephone: _____ (home)
_____ (work)
_____ (cell)
Email: _____
How can we best reach you? _____
May we leave messages pertaining to your child's visits: YES/ NO

Other parent/guardian authorized to make decisions regarding this minor child?
_____

With whom does this child live? _____

If custody is shared, please indicate the child's living arrangements
_____

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Emergency Contact:
Name: _____ Relationship: _____

Telephone: _____ (home)
_____ (work)
_____ (cell)

Does this child have any other siblings? YES/ NO
If yes, please list age and gender

_____

_____

_____

Other Health Care Providers your child is currently seeing:

Name: 1. _____ 2._____ 3._____

Telephone: _____ _____ _____

Type of provider: _____ _____ _____

(i.e. MD, Specialist, Chiropractor etc.)

Please list your child's foremost health concerns in order of importance:

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

How would you rate your child's current state of health?
Excellent Good Fair Poor

Current medications (prescription and over-the-counter) and supplements that your child is taking, including dosages and duration of use:

_____
_____
_____
_____

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Please list all allergies (food, environmental, drug):

_____
_____
_____
_____

Please list any past serious injuries or illnesses, including when they occurred and any complications that your child may have experienced:

_____
_____
_____
_____

Please list any hospitalizations or operations that your child has had, including why, when they occurred and any complications:

_____
_____
_____
_____

Has your child had any of the following illnesses?

□ Chicken Pox
□ Measles
□ Mumps
□ Rubella
□ Whooping Cough
□ Scarlet Fever
□ Roseola
□ Polio
□ Meningitis
□ Mononucleosis
□ Tuberculosis
□ Strep throat
□ Frequent Ear Infections
□ Rheumatic Fever

Please indicate which of the following vaccinations your child has received:

□ DPT
□ MMR
□ Polio
□ Haemophilus Influenza B
□ Flu Shot
□ Hepatitis A
□ Hepatitis B
□ Chicken Pox (Varivax)
□ Tetanus booster
□ Meningitis
□ Other _____

Has your child ever had an adverse reaction to a vaccine? If so, please indicate which vaccine and the nature of the adverse reaction: _____
_____

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How often has your child been treated with antibiotics? _____

How long ago was the last course? _____

FAMILY HEALTH HISTORY

Please indicate which family members (parents, siblings, grandparents), if any, have had or have the following conditions:

□ Diabetes _____
□ Heart Disease _____
□ High Blood Pressure _____
□ High Cholesterol _____
□ Stroke _____
□ Cancer _____
□ Seizures _____
□ Kidney Disease _____
□ Thyroid Dysfunction _____
□ Asthma _____
□ Allergies _____
□ Arthritis _____
□ Autoimmune disease _____
□ Osteoporosis _____
□ Depression _____
□ Schizophrenia _____
□ Alcohol/Drug abuse _____
□ Other Mental Illness _____
□ Other _____

Prenatal and Birth History

How would you describe the health of the parents at the time of conception?

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

How would you describe the health of the mother during the pregnancy?

Excellent Good Fair Poor Unknown

At what age did the mother of this child give birth? _____

Was this her first pregnancy? YES/ NO

Was there any difficulty conceiving this child? YES/ NO

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What, if any, interventions were used to increase the chance of conception?

_____

Please describe any health problems, stress, or complications, and the emotional state of the mother during pregnancy:

_____

_____

_____

Did the mother use any of the following during pregnancy? If yes, please list amounts and frequency of use:

□ Alcohol _____
□ Tobacco _____
□ Second hand smoke _____
□ Recreational Drugs _____
□ Prescription Drugs _____
□ Over-the-counter Drugs _____
□ Exposure to workplace chemicals explain) _____

Mother's weight gain during pregnancy _____

Length of pregnancy _____wks

Type of birth (circle): vaginal C-section Length of labour _____hrs

Interventions (circle): forceps vacuum epidural episiotomy other

Were there any complications during or immediately after labour & delivery? If so, please describe: _____

_____

_____

Postnatal History

Birth weight _____ Birth length _____

Were there any health concerns at birth? If yes, please describe:

_____

_____

In the first few weeks after birth, did your child experience any of the following?
□ congenital birth defect □ fever

□ infection
□ jaundice
□ skin conditions
□ colic
□ vomiting
□ restlessness
□ feeding difficulties
□ constipation

Age at first: _____ sitting _____ crawling _____ teething

_____ walking _____ talking

Any developmental delays or concerns? _____
_____
_____

Diet and lifestyle

How was your child fed? □ Breast fed. How long?_____
□ Formula fed. Milk/soy/other_____
□ Other _____
At what age were solid foods introduced into the child's diet? _____
What order, if any, did you follow in introducing foods? _____
_____
_____

Current Height _____ Current Weight _____

Any concerns about height or weight? _____

Please describe a typical day's diet for your child:

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages (including quantity): _____
Are there any foods which you exclude from your child's diet? For what reason?
_____

_____
How much water does your child consume per day? _____

Primary source of your child's drinking water (bottled, tap, filtered, well, etc)?
_____

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_____

What other beverages does your child drink & how much? _____

_____

How often does your child have a bowel movement? _____

How often does your child urinate (per day)? _____

Is your child regularly exposed to tobacco smoke or other environmental toxins at home?

_____

Are there pets in the home? _____

How would you rate your child's energy level on average? (10 being the most energy)

1 2 3 4 5 6 7 8 9 10

Is there anything that you notice that affects your child's energy level (increases or decreases)? _____

How many hours of sleep does the child get at night? _____

Do they have difficulty falling asleep? YES/ NO

Do they wake up during the night? YES/ NO If yes, how often? _____

Do they seem rested on waking? YES/ NO

Do they take naps? YES/ NO

If yes, how often & long? _____

Does your child exercise regularly? YES/ NO

What forms of exercise and how often? _____

_____

_____

How much time does your child spend outdoors per day? _____

How much time does your child spend watching television or using the computer per day?

_____

What are your child's interests/hobbies?

_____

_____

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How does your child feel about school/daycare? _____
_____

Please describe your child's disposition: _____
_____

How would you rate your child's stress level on average? (10 being the most stress)

1 2 3 4 5 6 7 8 9 10

What are sources of stress in your child's life? _____
_____

How would you describe the emotional climate of your home? _____
_____

Is there anything else that you would like to mention that has not been covered or feel it is important for me to know? _____
_____
_____

If your child is preadolescent or adolescent, please fill out the following questions and have your child fill out the accompanying confidential questionnaire for teens (age 14 -17) that follows the Review of Systems.

What information, if any, has your child been given about what changes they can expect during puberty? _____
_____

What information, if any, has your child been given about their sexuality, birth control, or protection from sexually transmitted diseases? _____
_____
_____

What information, if any, has your child been given about substances such as tobacco, alcohol, or recreational drugs? _____
_____

Do you have concerns or comments about any of these topics? _____
_____

Review of Systems

Please place a checkmark (√) next to any of the following symptoms that your child is currently experiencing and a (P) next to any that they have had in the past

SKIN & HAIR
__ Rashes
__ Itching
__ Eczema
__ Psoriasis
__ Boils/Cysts

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__ Acne
__ Hives
__ Warts
__ Dryness
__ Colour changes
__ Lumps
__ Dandruff
__ Hair loss
__ Change in hair texture
__ Nail changes

CARDIOVASCULAR
__ Rheumatic fever
__ Irregular heart beat
__ Fast heart beat
__ Slow heart beat
__ Palpitations
__ Murmurs
__ Cold hands or feet
__ Past ECG test
__ Other Heart tests
__ Other

EARS
__ Ringing
__ Discharge
__ Pain/Aches
__ Deafness
__ Infections
__ Wax build-up
__ Ear tubes
__ Other

RESPIRATORY
__ Cough
__ Sputum
__ Coughing blood
__ Wheezing
__ Asthma
__ Bronchitis
__ Pneumonia
__ Tuberculosis
__ Difficulty breathing
__ Pain with breathing
__ Other

NOSE & SINUSES
__ Allergies
__ Post nasal drip
__ Nosebleeds
__ Dryness
__ Sinus infections
__ Sinus pain
__ Nasal congestion
__ Sleep apnea
__ Snoring
__ Nasal Polyps
__ Other

EYES
__ Impaired vision
__ Glasses/contacts
__ Far-sighted
__ Near-sighted
__ Double vision
__ Colour blindness
__ Night blindness
__ Sensitivity to sun
__ Pain
__ Redness
__ Itching
__ Dryness
__ Discharge
__ Blurring
__ Excessive tearing
__ Spots/Floaters
__ Blind spot
__ Other

NOSE & SINUSES
__ Allergies
__ Post nasal drip
__ Nosebleeds
__ Dryness
__ Sinus infections
__ Sinus pain
__ Nasal congestion

__ Sleep apnea
__ Snoring
__ Nasal Polyps
__ Other

MOUTH & THROAT
__ Dental cavities
__ Mercury fillings
__ Gum problems
__ Grinding/Clenching
__ Ulcers/sores
__ Pain/Soreness
__ Frequent Sore throat
__ Hoarseness
__ Tonsillitis
__ Phlegm/Mucous
__ Cold sores
__ Enlarged glands
__ Jaw pain/clicking
__ Facial pain/tics
__ Other

HEAD & NECK
__ Headache
__ Injury
__ Lumps
__ Swollen glands
__ Swollen lymph nodes

__ Goitre
__ Pain/stiffness
__ Other

BLOOD & LYMPHATIC
__ Anemia
__ Easy bruising/bleeding
__ Slow clotting
__ Fatigue/weakness
__ Pallor (paleness)
__ Swollen lymph nodes
__ Past transfusions
__ Other

GASTROINTESTINAL
__ Heartburn/acid reflux
__ Indigestion
__ Poor/change in appetite
__ Poor/change in thirst
__ Difficulty swallowing
__ Abdominal pain/cramps
__ Bloating
__ Gas or belching
__ Bad breath

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__ Diarrhea
__ Constipation
__ incomplete bowel movements
__ Nausea
__ Vomiting
__ Vomiting blood
__ Spitting blood
__ Chronic laxative use
__ Rectal pain
__ Rectal bleeding
__ Rectal incontinence
__ Hemorrhoids
__ Blood in stool
__ Black, tarry stools
__ Undigested food in stool
__ Mucous in stool
__ Hernia
__ Ulcer
__ Candida
__ Intestinal worms

__ Liver disease
__ Gall bladder stones/disease
__ Jaundice
__ Anal itching
__ Anal fistula
__ Anal fissures
__ Food allergies
__ Other

GENITOURINARY
__ Frequent urination
__ Pain/burning on urination
__ Urgency to urinate
__ Urinary incontinence
__ Hesitancy with urination
__ Waking at night to urinate
__ Recurrent urinary tract infections
__ Kidney infection
__ Kidney stones
__ Blood in urine
__ Low back pain
__ Other

ENDOCRINE
__ Excessive urination
__ Excessive sweating
__ Heat intolerance
__ Cold intolerance
__ Thyroid disease
__ Excessive thirst
__ Excessive hunger
__ Diabetes
__ Hypoglycemia
__ Rapid weight gain
__ Rapid weight loss
__ Insomnia
__ Other

MUSCULOSKELETAL
__ Back pain
__ Muscle spasms/cramps

__ Muscle weakness
__ Arthritis
__ Tendonitis
__ Jaw pain/stiffness
__ Joint pain/stiffness
__ Joint swelling
__ Bursitis
__ Fractures
__ Other

NEUROLOGICAL
__ Dizziness
__ Seizures
__ Fainting__ Paralysis
__ Concussion
__ Numbness/Tingling
__ Speech difficulty
__ Poor coordination
__ Confusion
__ Learning difficulties
__ Developmental delays
__ Involuntary movements

__ Other

FEMALE REPRODUCTIVE
__ Heavy menses
__ Light menses
__ Irregular periods
__ Painful periods
__ Bleeding between periods
__ Menstrual blood clots
__ Vaginal discharge
__ Vaginal itching
__ Vaginal sores
__ Yeast infections
__ Fibroids
__ Ovarian cysts/PCOS
__ Endometriosis
__ Other

MALE REPRODUCTIVE
__ Testicular masses
__ Testicular pain
__ Hernia
__ Discharge or sores
__ Other

EMOTIONAL/PSYCHO SOCIAL

__ Depression
__ Anxiety
__ Mood swings or Irritability
__ Phobias

__ Hyperactivity
__ Aggression
__ Alcohol/Drug Abuse
__ Other

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By signing this form, I certify that all of the information provided herein is complete and accurate to the best of my knowledge. If there are any changes to this information I will notify The Natural Way Health Clinic in a timely manner. I give permission to be contacted by The Natural Way Health

Clinic as indicated in this form and for messages to be left at the indicated numbers. I give permission for an exchange of medical information to occur with those practitioners indicated within this form. I give permission for exchange of medical information to occur with other practitioners of The Natural Way Health Clinic, as needed for the purpose of consultation.

Please list exceptions: _____
Name of Patient or Guardian: _____
Signature: _____ **Date:** _____

Doctor: _____ License# : _____

Signature:_____ Date: _____