NORTH SAUGEEN NATUROPATHIC CLINIC
21, 1st Avenue South
Chesley, ON, N0G1L0
Phone: (905) 237-8521
Fax: (905) 237-8531
www.northsaugeenclinic.com

Child Intake Form

PLEASE COMPLETE THIS FORM AND RETURN IT TO CLINIC RECEPTION

Child's Name_____ Date _____

Date of birth: Date _____ Month _____ Year_____ Sex ☐M ☐F

Who is filling out this form (name and relation)? _____

Contacts (in order of preference):

Name _____ Address _____ _____	Phone: (Home) _____ (Work) _____ (E-mail) _____
Relationship to child	

Name _____ Address _____ _____	Phone: (Home) _____ (Work) _____ (E-mail) _____
Relationship to child	

Name _____ Address _____ _____	Phone: (Home) _____ (Work) _____ (E-mail) _____
Relationship to child	

With whom does the child live? _____

May we leave messages relating to your visits? ☐Y / ☐N Which Phone Number? _____

Emergency contact: Name _____

Phone number_____ Relation _____

How did you hear about our Clinic? Please check one of the following:

☐NSNC Website	☐Medical Doctor
☐NSNC Open House	☐Media/TV Article
☐NSNC Staff	☐Corporate Health/Wellness Event
☐NSNC Patient	☐Newsletter Delivery to Residence
☐Friend	☐NSNC Information Session
☐Family	☐Other _____

Referred by _____

Referred to _____

(Naturopathic Doctor at NSNC)

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Other health care providers the child is seeing:

1. Name _____ Address _____ _____ Phone (_____)_____ Fax (_____)_____	2. Name _____ Address _____ _____ Phone (_____)_____ Fax (_____)_____	3. Name _____ Address _____ _____ Phone (_____)_____ Fax (_____)_____

Last physician or health practitioner seen _____ When _____

When was your last physical exam? _____ Were blood tests done? ☐Y / ☐N

Blood type _____

What other screening tests has your child had? (hearing, vision etc.)? _____

_____

What is your main reason of coming today? _____

_____

What are your health concerns, in order of importance:

1. _____How long? _____
2. _____How long? _____
3. _____How long? _____
4. _____How long? _____
5. _____How long? _____

What kind of conventional treatment did the child receive?

_____

_____

Please mark all of the following complimentary health care practitioners the child has seen:

☐Naturopathic Doctor ☐Chiropractor ☐Acupuncturist ☐Massage Therapist ☐Osteopath ☐Other: _____

What was the therapy and what were the results?

_____

_____

_____

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MEDICAL HISTORY

How would you describe your child's general state of health? ☐Excellent ☐Good ☐Fair ☐Poor

How often does your child get colds, flus, sore throats in a year? _____

What is your child's current approximate weight _____ Height _____

Please list 5 most significant stressful events in your child's life:

1) _____ Date: _____
2) _____ Date: _____
3) _____Date:_____
4) _____Date: _____
5) _____Date: _____

Are any of these situations continuing to impact his/her life? ☐Y / ☐N (*If yes please circle the number*.)

Is your child currently working with a professional counselor, psychologist, social worker, pastor or other therapist?

_____

Have he/she in the past / when? _____

Please indicate any serious conditions, illnesses or injuries and any hospitalizations, along with approximate dates.

_____

_____

_____

_____

Does your child have any allergies (medicines, herbs, food, environmental, etc.)? _____

_____

_____

_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

_____

_____

_____

_____

Please list past prescription medications.

_____

_____

_____

_____

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Which of the following has your child had?

Rubella	☐Never ☐Mild ☐Average ☐Severe	Whooping cough	☐Never ☐Mild ☐Average ☐Severe
Measles	☐Never ☐Mild ☐Average ☐Severe	Strep throat	☐Never ☐Mild ☐Average ☐Severe
Chicken pox	☐Never ☐Mild ☐Average ☐Severe	Impetigo	☐Never ☐Mild ☐Average ☐Severe
Mumps	☐Never ☐Mild ☐Average ☐Severe	Mononucleosis	☐Never ☐Mild ☐Average ☐Severe
Roseola	☐Never ☐Mild ☐Average ☐Severe	Ear infections	☐Never ☐Mild ☐Average ☐Severe
Scarlet fever	☐Never ☐Mild ☐Average ☐Severe		

How many times has your child been treated with antibiotics? _____

Please indicate what immunizations your child had:

☐ DPT (diphtheria, pertussis, tetanus)	☐ Haemophilus influenza B	☐ Hepatitis A
☐ Tetanus booster; when? _____	☐ "Flu"	☐ Hepatitis B
☐ MMR (measles, mumps, rubella)	☐ Polio	☐ Smallpox

Other _____

Please indicate if any caused adverse reactions: _____

_____

PRENATAL HEALTH

What was the health of the parents at conception?

Mother ☐Poor ☐Fair ☐Good ☐Excellent ☐Unknown

Father ☐Poor ☐Fair ☐Good ☐Excellent ☐Unknown

What was the health of the mother during the pregnancy? ☐ Poor ☐Fair ☐Good ☐Excellent ☐Unknown

What was the mother's age at child's birth? _____

How was the mother's diet during pregnancy? ☐Poor ☐Fair ☐Good ☐Excellent ☐Unknown

Did the mother receive prenatal medical care? ☐Yes ☐No ☐Unknown

Did the mother experience any of the following during the pregnancy:

☐Bleeding	☐High blood pressure	☐Nausea	☐Vomiting
☐Diabetes	☐Thyroid problems	☐Physical or emotional trauma	

Did the mother use any of the following during the pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational drugs: _____

☐ Prescription medications: _____

☐ Over-the-counter medications: _____

☐ Supplements: _____

☐ Other: _____

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BIRTH HISTORY

Term length: ☐ Full ☐ Premature: _____ wks ☐ Late: _____ wks

Length of labour: _____ Weight at birth _____

Any complications? _____

Was the birth: ☐Vaginal ☐C-section ☐Induced ☐Forceps ☐Anesthesia used

Did the child experience any of the following at or shortly after birth?

☐ Jaundice ☐ Rashes ☐ Seizures ☐ Birth injuries _____

☐ Birth defects _____

☐ Other _____

DIET

How was your infant fed?

☐ Breast fed. How long? _____ ☐ Formula. Milk/Soy/Other: _____

☐ Other: _____

What foods were introduced before 6 months? (Please list approximate month as well.)

_____

_____

_____

6–12 months?

_____

_____

_____

Did your child ever experience colic? ☐Y ☐N How severe? ☐Mild ☐Moderate ☐Severe

Does your child have any food allergies or intolerances? Please list.

_____

_____

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____

_____

Describe a typical day's diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (and total quantity) _____

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HEALTH AND DEVELOPMENT

How was your child's health in the first year? ☐Poor ☐Fair ☐Good ☐Excellent ☐Unknown

At what age did your child first:

Sit up _____ Crawl _____ Walk _____ Talk _____

Dose your child have problem falling asleep? ☐Y/☐N Staying asleep? ☐Y/☐N How much does he/she sleep? ____hours

Does your child nap throughout the day? ☐Y/☐N How frequently and for how long? _____

_____

Please add to describe your child's sleep pattern: _____

_____

_____

Does your child perspire at night? ☐Slightly ☐Moderately ☐Heavily (please describe) _____

_____

How would you describe your child's temperament? _____

How would you describe your child's behaviour and performance at school? _____

_____

_____

How does your child learn? ☐Reading ☐Listening ☐Television ☐Very visual

FAMILY HISTORY

Indicate if a close relative (parent, grandparent, child, sibling) has had any of the following:

Condition	Please indicate which family member
Allergies	
Asthma	
Birth Defects	
Cancer	
Diabetes	
Drug Abuse/Alcoholism	
Kidney Disease	
Juvenile Arthritis	
Other _____	

☐ I don't know the family medical history

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ENVIRONMENT

Does your child have any siblings (gender, age) _____

Is the child in: ☐ School ☐ Daycare ☐ Home care ☐Other _____

What are your child's favorite activities? _____

_____

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

_____

Does the child exercise regularly? ☐Y ☐N How much, how often?

_____

_____

How much television does your child watch? _____ hrs a day/week

How often does your child read (not for school), or how often does someone read to your child?

☐ Daily ☐ Several times a week ☐ Weekly ☐ Less than weekly

Have your child travelled outside of Canada in the last 5 years? ☐Y / ☐N

Does anyone in the child's household smoke? ☐Y ☐N Are there animals in the home? ☐Y ☐N

How is the child's home heated? ☐ Natural Gas ☐ Oil ☐ Electric ☐ Wood ☐ Other _____

Is the home damp or moldy at all? ☐Y / ☐N

Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)? Please describe _____

_____

What does your child use for drinking water? ☐Tap water ☐Bottled Water ☐Filtered Water ☐Reverse Osmosis

Is there anything that you feel is important that has not been covered? _____

_____

_____

Thank you for taking time to fill in this questionnaire. It will be a valuable resource to evaluate your child's current health.

For file use only

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Well-Child Check Cover Sheet

This sheet will help explain some of the items on the Well-Child Check sheets. Note that Growth and Development covers the whole age range of the sheet, and not all items should be expected to be answered 'Yes'; refer to standard developmental check forms.

Lead (Pb)

These are screening questions for potential lead exposure:

1. Does the child live in or visit a house with peeling or chipping paint built before 1960 (home daycare, babysitter, relative, friend)?
2. Does the child live in or visit a house built before 1960 in which there is recent, ongoing, or planned renovation or remodeling?
3. Has any housemate or playmate been diagnosed with lead poisoning (< 15 mg/dl)?
4. Does the child live with an adult whose job or hobby involves exposure to lead (hobbies include ceramics, furniture refinishing, stained glass work)?
5. Does the child live near a lead smelter, battery recycling plant, or other source of lead?

Fall Prevention

Never leave a child alone in a high place (e.g., diaper changing table).
Always keep the sides of the crib raised.
No bunk beds before 6 years old.
No baby walkers.
Gates at the head and bottom of all stairs.

Hot Water

Do not hold hot drinks while holding the baby.
Never put anything hot (skillet/pan, curling iron, etc.) at the edge of a stove, table, etc.
Teach small children not to touch the faucets in the bath.
Keep hot water heaters turned below 55°C (130°F).

Car Seat

Children under 137 cm (54") must not sit in front of airbags (with or without child safety seat) – i.e., in back seat if there is a passenger-side airbag.
Children under 9kg (20lbs) sit in rear-facing safety seats.
Children 9-18 kg (20 – 40 lbs.) sit in forward-facing safety seats
Children 18-27 kg (40-60 lbs.) sit in booster seats with safety belts.
Children taller than 122 cm (48") sit with safety belts and shoulder harnesses.

Choking

Under 4 year: no nuts, orange seeds, cherry pits, raw carrots, raw peas, raw celery, Hot dogs, grapes, caramels, etc., must be chopped.
Watch for small parts on toys and household objects.
Teach sibling and sitters to follow these rules with the young child too.

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Poison Readiness

Includes having ipecac.

Includes knowing poison control centre number.

http://www.ontariopoisoncentre.com