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Child Intake Form

Name: _____ Age: ___ Grade: ___ Date of birth: _____ Sex: M/F Mother’s name:
Father’s name:
Sibling’s name (s) & age (s) _____ Home
address: _____ Home phone: _____

Child’s Doctor: _____ Phone: _____
Child’s Specialist: _____ Phone: _____

How did you find out about me? _____
If you have insurance coverage, please list name of insurer: _____
What would you like me to help your child with? _____

Please describe carefully any factors that you suspect may have played a role in its onset
and perpetuation: _____

Is your child’s health currently getting better, worse, or staying the same?
What treatments have been tried (please include both conventional and
complementary)? _____

Secondary health concerns you would like me to help your child with:

Have any of the above conditions been diagnosed? Yes/No
If yes, by whom? _____

Prenatal History:

What was the age of the child’s parents at the time of conception?
Mom ___ Dad: _____

What was their general state of health at the time?
Mother: Excellent ___ Good ___ Average ___ Fair ___ Poor ___ Unknown ___
Father: Excellent ___ Good ___ Average ___ Fair ___ Poor ___ Unknown ___

Type of prenatal health care received: **Midwifery/OB/GYN**

What was the health of the child's mother during pregnancy?

Excellent__Good__Average__Fair__Poor Unknown

How was the mother's diet during pregnancy?

Excellent__Good__Average__Fair__Poor Unknown

Did the child's mother experience any of the following during pregnancy:

Bleeding		Diabetes		Depression		Edema (swelling)	
Excessive weight gain		Emotional or physical trauma		Fainting		Herpes	
High blood pressure		Infections		Measles		Nausea	
Thyroid problems		Toxemia		Vomiting		Weight loss or excessive gain	

Other complications during pregnancy: _____.

Did mom use any of the following during pregnancy? Please indicate how much & for how long.

Prescription medications		Cortisone	
Supplements/herbs		Recreational drugs	
Alcohol		Tobacco	
Coffee		Laxatives	
Sedatives		Antacids	
Aspirin or Tylenol		Other OTC medications	

Please list any supplements/herbs taken during the pregnancy: _____.

How would you describe the pregnancy? _____.

Was there a history of complicated pregnancy prior to the birth of this child? _____.

Birth History:

Term length of gestation: **Full** Premature: _____wksLate: _____wks:

Was labour spontaneous? **Yes/No** If no, how was it induced? _____.

Length of labour: _____Complications of mother &/or infant during labour/delivery: _____.

Was the child's birth natural (ie. Without medical interventions such as episiotomy, forceps, vacuum, epidural, anesthesia, C-section..)?

Please explain in detail: _____.

Location of delivery: Home__ Hospital__ Other

At birth, what was the child's: Apgar score: __Weight __length

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

Allergic reaction		Birth defects		Birth injuries		Colic	
Difficulty feeding		Failure to thrive		Fevers		Hypoxia	
Jaundice		Meconium (in the lungs)		Meningitis		Rashes	
Respiratory distress		Seizures		Excessive weight loss		Excessive weight gain	

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

Billi-lights	
Drug administration	
Incubation	
Respirator	
Surgery	

Other complications after birth: _____.

Family Health History:

Please indicate if any of the following conditions apply to your immediate family:

Condition	Who	Condition	Who	Condition	Who
Allergies		Arthritis		Asthma	
Auto-immune disease		Birth defects		Bleeding disorders	
Cancer		Deafness		Depression	
Diabetes		Eczema		Frequent infections	
Hepatitis		HIV/AIDS		Kidney disease	
Mental illness		Speech problems		Visual problems	

Other: _____.

Do either of the parents have a chronic health condition? Yes/No

Please explain: _____.

Child's Health History:

How was your child's health in his/her 1st year of life:

excellent good fair poor unknown

Please indicate any serious conditions, illnesses, accidents, injuries, and hospitalizations, with approximate dates: _____.

_____.

_____.

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

_____.

Does your child have any known allergies (medicines, foods, environmental)?

_____.

Please list all CURRENT medications (prescription, over-the-counter, vitamins, herbs, homeopathics):

_____.

Please list all PAST medications:

_____.

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

Has your child been vaccinated? Yes/No

If yes, **standard/modified** schedule If modified schedule, please explain:

_____.

Has your child had any vaccinations in addition to those on the standard schedule?

_____.

Has your child ever traveled outside of Canada? Yes/No

If yes, where? _____.

Please indicate if any vaccinations caused any adverse or unusual reactions:

_____.

Nutritional History

Was your child breastfed? Yes/No If yes, for how long? _____.

If your child was not breastfed, please indicate what food was used, including brands.

_____.

Did your child experience colic? Y/N **mild moderate severe**

Until what age? _____.

What was the first liquid introduced to your child after this, & when (excluding water)

_____.

Please list solid foods given in the rough order of introduction:

Food	Age at introduction	Adverse reaction

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

_____.

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

How would you describe your child's eating habits: _____.

Please provide a rough outline of your child's daily diet, including quantities

Breakfast	
lunch	

Dinner	
Snacks	
Water intake	
Other fluids	

Review of Systems: Please mark the applicable with:

C=currently F=frequently O=occasionally
 S=seldom P=past N=never

Immune system

- Seasonal allergies
- Year-round allergies
- Asthma
- bronchitis
- Chronic cough
- ear infections
- Eczema/hives/rashes
- Eye infections
- Frequent colds
- fatigue
- Fungal infections
- Hearing loss
- High fevers
- Medical alert tag
- For what? _____
- Pneumonia
- Red/dry cheeks
- Rings under eyes
- Runny nose
- Sinusitis
- Sore throats
- Stomach flu
- Tonsilitis
- Wheezing

Other: _____

Childhood Infectious

Diseases:

- Chicken pox
- Croup
- Diphtheria
- German Measles (rubella)
- Impetigo
- Mononucleosis
- Mumps

Digestion

- canker sores
- colic
- abdominal cramps
- bloating
- constipation
- diarrhea
- food allergies
- gas
- hernia
- regular(1-3 BM/d)
- stomach aches
- blood in stool
- green/yellow stool
- mucus in stool
- nausea/vomiting

Dysbiosis

- fungal infections
- colic/gas
- craves sugar
- diaper rash
- thrush
- vaginal irritation

Skin

- acne
- Bumps on arms
- psoriasis
- other: _____

Skeletal

- arthritis
- fractures
- bone/growing pain
- spinal disorders
- other: _____

Urinary

- bed-wetting (> 6 yrs)
- bladder/ kidney infections
- frequent/painful urination
- kidney malformations

Mind/Disposition

- attention difficulties
- dyslexia
- hyperactive
- mentally challenged
- slow learner
- quick learner
- sleeping problems
- nervous/anxious/worried
- timid
- fearful
- phobias/unusual fears
- fearless
- aggressive/violent
- angry/irritable
- calm/relaxed
- sad/depressed
- happy
- sociable
- anti-social
- sensitive
- intuitive
- mood changes

Other

- breath/body odour
- emotional trauma
- hair loss
- headaches
- hearing problems
- heart condition

<input type="checkbox"/> Rheumatic fever		<input type="checkbox"/> lice/scabies/parasites
<input type="checkbox"/> Roseola	Blood	<input type="checkbox"/> night sweats
<input type="checkbox"/> Scarlet fever	<input type="checkbox"/> anemia	<input type="checkbox"/> vision problems
<input type="checkbox"/> Strep throat	<input type="checkbox"/> easy bleeding/bruising	
<input type="checkbox"/> Whooping cough	<input type="checkbox"/> nose bleeds other: _____	

Sleep History:

Please describe your child's sleep patterns: _____.

Does your child sleep through the night? Y/N hours of sleep nightly: __. Does your child nap during the day? Y/N

Does your child experience frequent nightmares/night terrors? Y/N

Social History:

How would you describe your child's temperament? _____.

How do you think others would describe your child? _____.

How does your child interact with others (adults & other children)?
_____.

How does your child handle stressful situations? _____.

How does your child express his/her emotions? _____.

How would you describe your child's performance at school/daycare?
_____.

Does your child take part in any extracurricular activities? _____.

_____.

Child's Environment:

Is your child in: **school daycare** **homecare** **other**

What are your child's favourite activities? _____.

Does your child exercise regularly? How much physical activity, how often?
_____.

How much TV does your child watch? __Hrs/day/week

computer time: __Hrs/day/week

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

How many people live in your home? __ Are there any smokers? Yes/No

Are there animals in the home? Yes/No What kind? _____.

How old is your home? ____ How is the home heated? _____.

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

_____.

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

Is there anything else that you would like to tell me about your child?
_____.

Thankyou for taking the time to fill out this lengthy questionnaire! It will be a valuable resource in helping to understand your child's health. Looking forward to working with you in the near future, Elly.