Dr. Nicole Rush, ND
Byron Natural Health Centre
1288 Commissioners Rd. W London, ON. N6K 1E1
519 601 5483 | www.nicolerushnd.com

CHILD INTAKE FORM

Our health is influenced by many different factors. Your child's health history is an important part and will provide valuable information for me to understand their current health. Please fill out this form and bring it with your child to the first visit.

GENERAL CONTACT INFORMATION

Name: _____ Today's Date: _____
(*Last name)* *(First name)* *(M/D/Y)*

Birthdate (M/D/Y): _____ Age: _____ Gender: _____

Who is filling out the form (Name and Relation)? _____

Contacts (in order of preference)

Name: _____ Relationship to child: : _____

Address:_____
Street *City* *Province* *Postal Code*

Phone (H): _____ (W): _____ (C): _____

E-mail: _____

Name: _____ Relationship to child: : _____

Address:_____
Street *City* *Province* *Postal Code*

Phone (H): _____ (W): _____ (C): _____

E-mail: _____

May we leave you a message about your appointment: Y N Which Number? _____

With whom does the child live with? _____

How did you hear about the clinic? _____

Medical Doctor: _____ Last Visit: _____
Name *Telephone* *(M/Y)*

PERSONAL MEDICAL HISTORY

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

What are your child's health concerns, in order of importance?

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

Please list any other Healthcare Providers your child is currently seeing:

Name	*Phone Number*	*Reason*
Name	*Phone Number*	*Reason*
Name	*Phone Number*	*Reason*

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

1. _____
2. _____
3. _____

Does your child have any allergies or hypersensitivities to any of the following?
Foods: _____

Medicines: _____

Environment: _____

Other: _____

Please list all prescription and over the counter medications, vitamins or other supplements your child is currently taking:
_____

_____

_____

_____

Vaccination/Immunization Record: Check all that apply
Please note vaccinations in **bold** are routine as per the Ontario Childhood Immunization Schedule 2004

- ☐ **DPT (Diptheria, Pertussis, Tetanus)**
- ☐ **MMR (Measles, Mumps, Rubella)**
- ☐ Gardasil/Cervarix (HPV Vaccine)
- ☐ Haemophilus Influenza B
- ☐ BCG (Tuberculosis)
- ☐ Hepatitis A
- ☐ **Hepatitis B**
- ☐ **Polio**
- ☐ Flu Vaccine
- ☐ **Pneumococcal Conjugate (Meningitis/Pneumonia)**
- ☐ **Meningococcal C Conjugate (Meningitis)**
- ☐ **Virivax/Varilrix (Chicken Pox)**

Did any of your child's vaccines cause adverse reactions? Y / N If yes, please list:

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

Has your child had any of the following?

	Never	Mild	Average	Severe
Rubella (German Measles)				
Measles				
Chicken pox				
Mumps				
Roseola				
Scarlet Fever				
Whopping Cough				
Strep Throat				
Impetigo				
Mononucleosis				
Ear infections				

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

_____

_____

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 ☐ Physical or Emotional Trauma

☐ Diabetes ☐ Thyroid Problems ☐ Vomiting

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

☐ Tobacco ☐ Alcohol

☐ Recreational Drugs: _____

☐ Prescription medications: _____

☐ Over the counter medications: _____

☐ Supplements: _____

☐Other: _____

BIRTH HEALTH

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

Length of labor: _____ Weight at birth: _____

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

Any complications? _____

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

☐ Jaundice ☐ Rashes ☐ Seizures ☐ Failure to thrive ☐ Respiratory distress
☐ Colic ☐ Hypoxia ☐ Surgery ☐ Difficulty Feeding ☐ Meningitis
☐ Respiratory distress ☐ Other: _____
☐ Birth defects_____ ☐ Birth injuries _____

DIET

How was your infant fed?
☐ Breastfed. How long? _____ ☐ Formula: Milk/ Soy/ Other: _____
☐ Other: _____

What foods were introduced before 6 months? (Approximately which months)

_____
_____
_____

6 – 12 months?

_____
_____
_____

Did your child ever experience colic? ☐ Yes ☐ No 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 for your child:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages (and total quantity): _____

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: _____

Describe your child's sleep patterns:

_____
_____

How would you describe your child's temperament?

_____
_____

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

_____

_____

FAMILY HISTORY

Please indicate if a close relative (Parent or sibling has had any of the following:

Condition	When? (Their age)	Family Member
Allergies/ Hay Fever		
Asthma		
Birth defects		
Diabetes		
Juvenile arthritis		
Kidney Disease		
Eczema		

Do either of the parents have a chronic illness? ☐ Yes ☐ No Please explain:

_____

_____

ENVIRONMENT

Is your child in: ☐ School ☐ Daycare ☐ Homecare ☐ Other: _____

What are your child's favorite activities?

_____

_____

_____

Does your child exercise regularly? ☐ Yes ☐ No How much and how often?

_____

_____

_____

How much television does your child watch? _____ hours 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

Does anyone in the child's household smoke? ☐ Yes ☐ No

Are there animals in the home? ☐ Yes ☐ No

How do you describe the emotional climate of the child's home?

_____

_____

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

_____

_____

_____