VITALITY HEALTH

411 Huronia Road Unit 6A
Barrie, ON L4N 9B3
705.733.2033
www.vitalityforlife.ca

Contact Information

Full Name:_____ Date of Birth:_____
Day/Month/Year

Sex: M F Marital Status:_____

Email:_____

Occupation:_____

Address:_____

_____

_____

Telephone: (home)_____ (work)_____

Name of Medical Doctor:_____

Telephone:_____

Date of last visit to Medical Doctor:_____

Date of last physical exam:_____

How did you hear about our clinc?_____

Have you been treated by a Naturopathic Doctor before? Yes No

If 'yes' by whom?_____ When?_____

In Case of Emergency:

Contact:_____ _____ _____
Name Relation Telephone

_____ _____/_____/_____
Signature Date: Month/ Day / Year

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Child Intake Form

Please fill out this form to the best of your ability. It will help to assess your child's present health and will assist in facilitating the healing process.

Preferred First Name: _____Last Name: _____

Age: _____ Height: _____ Weight: _____

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

1.

2.

3.

How would you describe your child's general state of health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

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

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

Which of the following has your child had? (n – never, m – mild, a – average, s – severe)

n	m	a	s	rubella (german measles)	n	m	a	s	roseola
n	m	a	s	measles	n	m	a	s	scarlet fever
n	m	a	s	chicken pox	n	m	a	s	mumps
n	m	a	s	whooping cough	n	m	a	s	strep throat
n	m	a	s	impetigo	n	m	a	s	mononucleosis
n	m	a	s	ear infections					

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

Please list past prescription medications. _____
_____
_____

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

Please indicate what immunizations your child has had.

☐Chicken pox (varicella)
☐MMR (measles/mumps/rubella)
☐DTP (diphtheria)
☐Tetanus booster; when? _____
☐Haemophilus influenza B
☐Influenza (flu)
☐Meningococcal (meningitis)
☐Polio
☐Hep A
☐Hep B

Other _____

Please indicate if any caused adverse reactions.
_____

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

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 ☐ Other _____

Did the mother use any of the following during pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational drugs: _____
☐ Prescription medications: _____
☐ Over-the-counter medications: _____
☐ Supplements: _____
☐ Other: _____

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 milk. How long? _____ ☐ Formula: Cow'/Goat/Soy milk. _____
☐ Other: _____

What foods were introduced before six months? (Please list approximate month.)
_____
_____
_____

6 – 12 months?
_____
_____
_____
_____

Did your child experience colic? Y N
How severe was the colic? 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) _____

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 _____ Show teeth _____

Describe your child's sleep pattern. _____

How would you describe your child's temperament? _____

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

FAMILY HISTORY

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

	Who?		Who?
Allergies		Diabetes	
Asthma		Kidney disorder	

Birth defects		Other	
Juvenile arthritis			

☐ I don't know the family history

Do either of the parents have a chronic illness? Y N Please describe _____
_____

ENVIRONMENT

Is the child in: school daycare home care other _____

What are you child's favourite activities? _____
_____

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

How much television does your child watch? _____ hours

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

☐ daily ☐ several times a week ☐ weekly ☐ less than weekly

Does anyone in the child's household smoke: Y N

Are there any animals in the home? Y N

How is the child's home heated? _____

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

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

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

4 Day Diet Diary

Please keep track of all foods that are eaten (don't worry about quantities) for 4 days, and note the time that you ate them. Include all beverages and snacks consumed during this time as well, and comment on how you felt throughout the day (energy level, indigestion, bloating/gas).

Day:			
Morning:			
Afternoon:			
Evening:			
Comments:			