Natural Harmony Chinese Medicine Clinic
Kim Cooper R.TCM.P

INTAKE FORM FOR CHILDREN

Child's Name _____ Sex _____ Age _____
Child's date of birth (dd/mm/yy) _____
Child's Address _____City _____ PC _____
Caregiver's Name(s) _____
Address if different from above: _____
Phone: Home: _____
Emergency contact: _____
Siblings (name and ages) _____
Family Doctor/Pediatrician
Phone _____ Address:_____
What are your major concerns about your child's health? _____
_____
_____
Are there any other concerns about your child's health?_____
_____
_____
Have any of the above conditions been diagnosed? Y N If so, by whom? _____

MEDICAL HISTORY

How would you. describe your child's general state of health? Good Fair Poor
Which of the following has your child had? (n-never, m-mild, a-average, s-severe) please circle:
(n m a s) rubella (German measles) (n m a s) roseola (n m a s) impetigo
(n m a s) measles (n m a s) scarlet fever (n m a s) mononucleosis
(n m a s) chickenpox (n m a s) strep throat (n m a s) ear infections
(n m a s) mumps (n m a s) whooping cough
Please list any medications (including over-the-counter, vitamins, homeopathics, herbs etc):
Taken in the past: _____
_____
_____
Presently: _____
_____
_____
Please indicate what immunizations your child has had:
□ DPT (diptheria, pertussis, tetanus) □ Tetanus booster, when? _____
□ MMR (measles, mumps, rubella) □ Haemophilus influenza B
□ "flu" □ Hepatitis A□ Polio□ Other
Please indicate if any caused adverse reactions _____
How many times has your child been treated with antibiotics? _____
When and for what reason?_____
Dental history/extractions or cavities?_____
List all locations of child's scars_____

PRENATAL HEALTH

What was the state of the Mother during 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? Y N Unknown
Did the mother experience any of the following during pregnancy?
□ bleeding □ High blood pressure □ nausea □ vomiting
□ diabetes □ Thyroid problems □ Physical or emotional trauma
Other? _____

Did the Mother use any of the following during the pregnancy? (Please give details)
□ Tobacco _____
□ Alcohol _____
□ Recreational drugs _____
□ Prescription drugs _____
□ Over-the-counter medication_____
□ 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 □ Anaesthesia used
Did the child experience any of the following symptoms 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 months 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.
_____
_____
_____
_____
Do either of the parents have a chronic illness? Y N Please describe:
_____
_____
_____
_____

DIET

Does your child have any dietary restrictions (religious, vegetarian/vegan etc.)?
_____
_____
Describe a typical diet:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages (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 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 disease

Birth defects Juvenile arthritis

□ I don't know the family medical history

ENVIRONMENT

Is your child in: school (grade ? _____) daycare homecare other _____

What are your child's favourite activities?

_____

_____

_____

_____

Does your 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

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

Are there animals in the home? Y N Type: _____

How is your child's home heated? _____

Do you know of any toxins or other hazards the child is regularly exposed to (home, hobbies etc?)

Please describe.

_____

_____

_____

_____

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

_____

_____

_____

_____

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

_____

_____

_____

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DECLARATION AND CONSENT TO TREATMENT OF A CHILD

Child's name: _____ Date:_____
(First) (Middle) (Last)

I, _____, hereby give my consent for Dr. Caroline Harvey-Smith Ph.D., ND. Doctor of Naturopathic Medicine to treat my child or ward.

I take responsibility for all fees incurred.

Signature_____ Date_____

Relationship to child: _____

Witness's signature: _____ Date: _____