

The Lilac Naturopathic Clinic

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Child Intake Form

Our practice is dedicated to providing the best possible care for your child. In order for us to serve you better, please take a few minutes to answer the following questions. Your answers will be kept strictly confidential as part of your child's medical record.

Child's Name: _____ Child's Age: _____
(Last) (First) (Middle)

Date of Birth: ___/___/___ Sex: ___M ___F Child's grade level: _____
dd mm yy

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

How did you learn about our clinic? _____

Who does the child live with? _____

Address: _____
(Street #) (Apt #)

(City) (Province) (Postal Code)

(Home Phone) (Work Phone) (Fax)

Occupation: _____ Full Time _____ Part Time

Are you: _____ Single _____ Married _____ Separated _____ Divorced
_____ Widowed _____ Living with a partner _____ Other

Emergency Contact Information:

Name and relation to child: _____

Address: _____

Phone Number: _____ Home/ _____ Work/ _____ Cell

Name and relation to child: _____

Address: _____

Phone Number: _____ Home/ _____ Work/ _____ Cell

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****Naturopathic and preventative health care is only possible when the doctor has a complete picture of the client physically, mentally, and emotionally. Therefore, please take the time to thoroughly complete this health questionnaire. ****

When was the child's last physical exam? _____
(Month) (Year)

Who is the child's family physician? _____
(Name) (City)

When was his/her last visit to a dentist? _____
(Month) (Year)

Who is his/her regular dentist? _____
(Name) (City)

Does he/she have mercury fillings? ____ Yes ____ No Number of Fillings: ____

When did he/she last visit an optometrist? _____
(Month) (Year)

Who is his/her regular optometrist? _____
(Name) (City)

Is he/she under the care of any specialists? **Yes/No** _____
(Name) (Specialty) (City)

Is he/she receiving other health care? **Yes / No:** _____

Please list any additional health care providers with their designation (pediatrician, family physician, etc.) and contact information:

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Primary Health Concerns:

How would you rate the General Health of your child: (1 being poor, 10 being excellent)

poor 1 2 3 4 5 6 7 8 9 10 excellent

In your opinion, what are your child's most important health concerns in order of importance?

Complaint	Since	Possible Cause(s)

What medications/supplements is your child currently taking?
(prescription/over-the-counter/supplements/vitamins/minerals etc)

Medication/Supplement	Since	Adverse Effects

List all surgeries he/she has had:

Procedure	Year	Complications?

List any major injuries you have sustained:

Injury	Year	Long Term Effects

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Any Allergies to medications? _____

Allergies to other substances (foods/inhalants)? _____

Bowel/ Urinary Habits:

Frequency of stool _____ times per day, _____ times per week

Does your child experience any pain when passing stool? _____ Yes _____ No

Do any of your child's bowel habits concern you?

Are there any urinary symptoms you are concerned about?

Has your child ever experienced any of the following conditions? If you are unsure of any of the terminology please put a question mark beside the word.

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies – seasonal | <input type="checkbox"/> Conjunctivitis (pink eye) | <input type="checkbox"/> Head Lice |
| <input type="checkbox"/> Allergies – environmental | <input type="checkbox"/> Constipation | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Cradle Cap | <input type="checkbox"/> Impetigo |
| <input type="checkbox"/> Atopic Dermatitis | <input type="checkbox"/> Croup | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Diaper Rash | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Difficulty Concentrating | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Chronic Bedwetting | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Chronic Bleeding noses | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Chronic Bruising | <input type="checkbox"/> Eczema | <input type="checkbox"/> Thrush |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Urinary Infection |

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Vaccinations:

Vaccine	Age	Adverse Reactions
Hepatitis B		
DPT or DT – Diptheria, Pertussis, Tetanus		
Polio		
Hemophilus B		
MMR – Measles, Mumps, Rubella		
Tetanus		
Varivax (Chicken Pox)		
Flu Vaccine		
Other		

If a sibling of the child has had an adverse reaction to any of the above vaccinations please describe reaction here:

Has your child ever been exposed to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals (lead, mercury, cadmium, arsenic, etc) while at school, home, or traveling?

Yes / No _____

Siblings

Name _____ Age _____ General health: **Poor Fair Good**

Name _____ Age _____ General health: **Poor Fair Good**

Name _____ Age _____ General health: **Poor Fair Good**

Which of the following ailments listed, or any others, have affected the parents or siblings?

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Strep throat |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Easy Bleeding | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sickle Cell Anemia | |

Any other medical conditions? _____

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LIFESTYLE:

What are some of your child's favorite activities/ hobbies: _____

Does your child have any fears? _____

What are your child's favorite foods and how often are they eaten? _____

What type of pets do you own? _____

Does anyone in the house smoke? **Yes / No**

How many hours of TV/video games/computer games does your child engage in daily?

How would you rate your child's academic performance (if appropriate)

poor

fair

good

excellent

What time does your child go to bed? _____ Wake up? _____

Does your child take naps? **Yes / No** When? _____

Do they have any trouble falling asleep? _____

Do they sleep straight through the night? _____

Do they wake up looking/acting refreshed? _____

Do they have any recurring dreams or nightmares? _____

Please write a short description of your child as he/she is currently. Include strengths, weaknesses and major personality traits:

Is your child currently in school, daycare, at home? _____

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How would you describe your child's behaviour in school/ daycare ? _____

Does this differ greatly from behaviour at home? _____

What makes your child angry? _____

Do they have any difficulties expressing anger? _____

Do they experience uncontrollable rage? _____

How does he/she express anger? _____

What makes your child sad? _____

Does he/she cry when sad? _____

List major experiences of grief or loss in your child's life? _____

PRE-NATAL HEALTH AND BIRTH HISTORY:

How old was the mother at the time of the child's birth? _____

Number of previous pregnancies the mother carried to term? _____

Number of previous pregnancies not carried to term? _____

	Excellent	Good	Fair	Poor
How was the health of the mother at time of conception?				
How was the health of the father at time of conception?				
How was the health of the mother during the pregnancy?				
How was the emotional state of the mother during pregnancy?				
How was the mother's diet during pregnancy?				

Did the mother use any alcohol, cigarettes or recreational drugs during pregnancy?

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Did the mother use any prescription drugs during pregnancy? _____

Did the mother use any over the counter medications during pregnancy? (ex/ Tylenol)

Did the mother use any supplements or vitamins during pregnancy? _____

Were there any interventions used during the pregnancy? (e.g. ultrasound or amniocentesis) _____

Were there any interventions used during the delivery? (e.g. epidural or forceps)

Were there any complications during the delivery? _____

Weight of infant at birth: _____ Term length of pregnancy (weeks): _____

Did the infant experience any of the following conditions during or following the birth?

injuries during the birth birth defects jaundice infections

DIET HISTORY:

Breast fed? **Yes / No** How long? _____ Was it easy/difficult? _____

Approximate feeding schedule? _____

Formula? _____ How long? _____ Combined with breast milk? _____

What type of formula was used? (milk, soy, other) _____

At what age was solid food first introduced? _____

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What types of food were introduced and in what order? _____

Did your child have any reaction to the food being introduced? _____

Does your child have any current food allergies? _____

Does your child have any dietary restrictions? (ex/ religious or vegetarian) _____

List any foods that your child seems to crave, regardless of their nutritional value (includes sweets, chocolate, salty, sour, bread, rich/fatty foods etc.): _____

Is your child frequently thirsty? **Yes / No** Amount of liquid child drinks each day? _____

Amount of plain water: _____

What temperature of liquid does your child prefer to drink? **Hot / Cold / Room Temperature**

Are you satisfied with your child's diet the way that it is now? Why or why not? _____

Please bring the completed forms to your first visit

Thank you for your time and patience, the information collected by this form will be kept confidential and will assist us with providing the best care possible for your child. If you have any questions please feel free to contact us so that we may provide clarification.

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