Affinity Health Clinic

Naturopathic Intake Child 0-4 years

Patient Information **Date:**

Child's Name: _____

Parent's/Guardian's names:_____

Home Address: _____ APT# _____

City: _____ Prov. _____ Postal code _____

Home Phone: _____ Cell _____

Work Phone: _____ ext. _____ Email:_____

Birth Date (dd-mm-yy): _____

Height (of child): _____ Weight (of child): _____ Sex:_____

Siblings and ages: _____ _____

Emergency Contact: _____Telephone: _____

Who recommended our services to you? _____

The best way to connect with you when we have clinic news: □ Facebook □ Email □ Other

Name of Family Doctor:_____ Phone # _____

Names of any illnesses and or conditions diagnosed by family doctor:

May we communicate with your MD regarding your child's care if necessary? □Y □ N

What is the main concern for you about your child?

Describe any factors you suspect may have played a role in its onset and continuation:

Affinity Health Clinic
3 waterloo Street
New Hamburg, On
N3A 1S3

www.affinityhealthclinic.ca
519-662-2123
wecare@affinityhealthclinic.ca

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Prenatal history

Your child is: ☐ genetically yours ☐ Adopted ☐ Prenatal history unknown			
Complications during pregnancy? Please explain briefly			
Ultrasounds during pregnancy? How many	Y	N	
Did you take medications during pregnancy? Please write down			
Exposure to alcohol, cigarettes, or second hand smoke during pregnancy?	Y	N	

Birth experience

Location of birth: ☐ Home ☐ Hospital ☐ Birthing Centre ☐ Other			
Birth Attendants ☐ Midwife ☐ Doula ☐ MD ☐ OB ☐ Other			
Medications during labor/delivery? Which ones?	Y	N	
Was Pitocin used to induce/speed up labor?	Y	N	
Was your delivery: ☐ Vaginal ☐ C-Section			
If a vaginal birth, was the baby presented: ☐ Head ☐ Face ☐ Breech			
Were any interventions used? ☐ Forceps ☐ Vacuum extraction ☐ Other			
Any complications or concerns you have about the birth?			

Vaccination and Medicine history

Has your child been vaccinated?	Y	N	☐ Delayed or selective schedule ☐ Regular schedule
Any reactions to the vaccinations?	Y	N	☐ Fever ☐ Welt at injection site ☐ Rash ☐ Diarrhea ☐ Fatigue ☐ Seizures ☐ Developmental Regression

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Has your child had antibiotics? How often?	Y	N	
Has your child been exposed to any medications, including OTC? Which ones?	Y	N	
Has your child been on any natural medicines? Which ones?	Y	N	

Developmental history

Has your child had any accidents? Please state.	Y	N	
Has your child been seen at the emergency department? Please describe.	Y	N	
Has your child broken a bone?	Y	N	
Has your child had any previous hospitalizations? When?	Y	N	
Has your child had any previous surgeries? When?	Y	N	

Review of Systems

Skin, Hair and Nails

Rashes - specify	Y	P	N	
Skin conditions - specify	Y	P	N	
Dry skin	Y	P	N	
Itching	Y	P	N	
Changes in skin color	Y	P	N	
Sunburn (how often?)	Y	P	N	
Warts	Y	P	N	
Lumps or abscesses	Y	P	N	
Excessive perspiration	Y	P	N	
Night sweats	Y	P	N	

Musculoskeletal

Growing pains	Y	P	N	
Joint swelling/redness	Y	P	N	
Muscle spasm/cramps	Y	P	N	
Muscle weakness	Y	P	N	
Bone fractures	Y	P	N	

Neck pain	Y	P	N	
Back pain	Y	P	N	
Tip Toe walking	Y	P	N	

Head, Nose, Mouth and Throat

Headaches/Migraines	Y	P	N	
Head injury	Y	P	N	
Torticollis/Head Tilt	Y	P	N	
Strep throat	Y	P	N	
Tonsillitis	Y	P	N	
Gum problems	Y	P	N	
Teeth problems	Y	P	N	
Nose bleeds	Y	P	N	
Sinus stuffiness/ lots of mucus	Y	P	N	

Ears

Impaired hearing	Y	P	N	
Earaches/infections	Y	P	N	
Itchy ear canal	Y	P	N	
Discharge from ear	Y	P	N	

Immune

Recurrent fevers	Y	P	N	
Cold sores	Y	P	N	
Frequent antibiotics	Y	P	N	
Frequent colds/croup	Y	P	N	
Frequent sore throat	Y	P	N	
Swollen glands/lymph nodes	Y	P	N	

Respiratory System

Chronic cough	*Y*	*P*	*N*	
Chronic phlegm	Y	P	N	
Wheezing	Y	P	N	
Asthma	Y	P	N	

Gastrointestinal and Feeding

Digestive problems	Y	P	N	
Change in appetite	Y	P	N	
Trouble swallowing	Y	P	N	
Frequent diarrhea	Y	P	N	
Constipation	Y	P	N	
Jaundice	Y	P	N	

Gas/Flatulence	Y	P	N	
Nausea	Y	P	N	
Frequent vomiting /spitting up	Y	P	N	
Colic	Y	P	N	
Food sensitivities, allergies, intolerance?	Y	P	N	
Does your child frequently arch his/her head and neck backwards?	Y	P	N	
Is your child exposed to cow's milk/dairy? How?	Y	P	N	
Is your child exposed to gluten? How?	Y	P	N	
Was your child breastfed? How long?	Y	P	N	
Did your child have formula?	Y	P	N	
What age did you begin introducing solid foods?				

Urinary System

Bed wetting	Y	P	N	
Strong odor	Y	P	N	

Endocrine

Diabetes	Y	P	N	
Excessive hunger	Y	P	N	
Excessive sweating	Y	P	N	
Excessive thirst	Y	P	N	
Excessive urination	Y	P	N	
Weight challenges	Y	P	N	

Sleep

Fall asleep easily	Y	P	N	
How many hours does your child sleep?	Y	P	N	
Difficulty falling asleep	Y	P	N	
Do not sleep/Insomnia	Y	P	N	
Night terrors	Y	P	N	

Mental/Emotional

Frequent crying spells	Y	P	N	
Angry outbursts	Y	P	N	

Neurological/Other

Failure to thrive	Y	P	N	
Slow or absent reflexes	Y	P	N	

Asymmetrical crawling	Y	P	N	
Regression of Milestones	Y	P	N	
Tremors/shaking	Y	P	N	
Seizures	Y	P	N	
ADD/ADHD	Y	P	N	
Autism/PPD	Y	P	N	

General

Please indicate Y=Yes N=No and explain further where applicable

Does your child eat gluten?	Y	N	
Does your child consume dairy?	Y	N	
Does your child eat refined sugars? (white sugar, white pasta and bread?)	Y	N	
Does your child drink juice? How many times a day?	Y	N	□ 1-3 □ 4-6 □ 7-10
Does your child drink water? How many times a day?	Y	N	□ 1-3 □ 4-6 □ 7-10
Does your child drink pop? How many times a day?	Y	N	□ 1-3 □ 4-6 □ 7-10
Does your child eat boxed/frozen foods? How many times a day?	Y	N	□ 1-3 □ 4-6 □ 7-10
Do you choose organic foods? Which ones?			□ meat □ eggs □ fruit □ vegetables □ milk □ grains

Toxic Exposure

Please indicate Y=Yes N=No and explain further where applicable

Has your child been exposed to mold, solvents, fumes, heavy metals, lead paint?	Y	N	
Has your child been exposed to second hand smoke?	Y	N	
Do you live near power lines?	Y	N	
Does your home have a lot of wireless exposure?	Y	N	