



## Affinity Health Clinic

### Naturopathic Intake Form Child 5-16 years

<b>Patient Information</b>	<b>Date:</b>
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: <input type="checkbox"/> Facebook <input type="checkbox"/> Email <input type="checkbox"/> 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? <input type="checkbox"/> Y <input type="checkbox"/> 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  
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### Prenatal history

Your child is: <input type="checkbox"/> genetically yours <input type="checkbox"/> Adopted <input type="checkbox"/> 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: <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Birthing Centre <input type="checkbox"/> Other			
Birth Attendants <input type="checkbox"/> Midwife <input type="checkbox"/> Doula <input type="checkbox"/> MD <input type="checkbox"/> OB <input type="checkbox"/> Other			
Medications during labor/delivery? Which ones?	Y	N	
Was Pitocin used to induce/speed up labor?	Y	N	
Was your delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section			
If a vaginal birth, was the baby presented: <input type="checkbox"/> Head <input type="checkbox"/> Face <input type="checkbox"/> Breech			
Were any interventions used? <input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum extraction <input type="checkbox"/> Other			
Any complications or concerns you have about the birth?			

### Vaccination and Medicine history

Has your child been vaccinated?	Y	N	<input type="checkbox"/> Delayed or selective schedule <input type="checkbox"/> Regular schedule
Any reactions to the vaccinations?	Y	N	<input type="checkbox"/> Fever <input type="checkbox"/> Welt at injection site <input type="checkbox"/> Rash <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fatigue <input type="checkbox"/> Seizures <input type="checkbox"/> 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	

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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	
Does your child have any mercury fillings?	Y	P	N	
Does your child have any composite fillings?	Y	P	N	
Has your child had an abscessed tooth?	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	

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### 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	

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### 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	<input type="checkbox"/> 1-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-10
Does your child drink water? How many times a day?	Y	N	<input type="checkbox"/> 1-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-10
Does your child drink pop? How many times a day?	Y	N	<input type="checkbox"/> 1-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-10
Does your child eat boxed/frozen foods? How many times a day?	Y	N	<input type="checkbox"/> 1-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-10
Do you choose organic foods? Which ones?			<input type="checkbox"/> meat <input type="checkbox"/> eggs <input type="checkbox"/> fruit <input type="checkbox"/> vegetables <input type="checkbox"/> milk <input type="checkbox"/> grains
Does your child exercise? How often and kind? (cardio, walking, weight bearing)	Y	N	
Does your child play contact sports?	Y	N	
Does your child spend time in front of screens? How many hours?	Y	N	<input type="checkbox"/> 0-1 <input type="checkbox"/> 1-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-10
For School performance where is your child at?	Academics: <input type="checkbox"/> Above average <input type="checkbox"/> Average <input type="checkbox"/> Below average Concentration: <input type="checkbox"/> Above average <input type="checkbox"/> Average <input type="checkbox"/> Below average Social Interaction: <input type="checkbox"/> Above average <input type="checkbox"/> Average <input type="checkbox"/> Below average		



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### 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	
Do you wireless technology in your home?	Y	N	
Do you live near power lines?	Y	N	
Do you live near power lines?	Y	N	
Do you live near power lines?	Y	N	