Holistic Clinic
Integrated Health Care

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Naturopathic Child Intake

(To be completed by the parent / guardian of a child 12 years old or younger)

PATIENT INFORMATION Today's date(day/mo/yr):_____/_____/_______

Child's name: ____ Sex: M / F

Child's date of birth (day/mo/yr): _____/_____/__________ Child's age: ___________

Parent / guardian's name: ____

Address with postal code: ____

Tel(home): (_____) ____________________ (work): (_____) ____________________

Parent's email: ____

Child's pediatrician / doctor: ________________________________ MD Tel: (_____) ____________________

Other healthcare providers: ____

How did you hear about D. Korah, ND? Referral from: ________________________________ Yellow pages ______
naturopathic-doctor.ca _____ holisticclinic.ca _____ Specify other: _______________________

Optimal health is only possible when the doctor has a complete understanding of the patient. Your time, thoughtfulness and honesty in completing this confidential overview will greatly assist my understanding of the healthcare needs of your child.

HEALTH INFORMATION

What is your main health concern about your child's health? ____
____
____
____

Has a diagnosis been made regarding your child's main health concern? Y / N
Who made the diagnosis? _________________________________
How has this condition been treated until now? ____
____

What else would you like to see changed in your child's health?
1. ____
2. ____
3. ____

Child's Health History

Please list all **current** medications and supplements your child is on. Indicate how long he/she has been taking it.

Medication / supplement	How long?	Medication / supplement	How long?
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Please list all **past** medications your child has taken.

Medication	Illness	Adverse reaction?
1.		
2.		
3.		
4.		
5.		

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

Please indicate the childhood diseases that your child has had. Include whether it was mild, average, or severe.

Disease	Age	Severity	Disease	Age	Severity
Asthma			Pertussis (whooping cough)		
Chickenpox			Pneumonia		
Eczema			Rheumatic fever		
Fifth's disease			Roseola		
Frequent ear infections			Rubella (German measles)		
Impetigo			Rubeola (Measles)		
Mononucleosis			Scarlet fever		
Mumps			Strep throat		

What vaccinations has your child had?

Vaccination	Age	Adverse reaction?
Chicken pox		
DPT		
Flu shot		
Hepatitis B		
Hemophilus influenza B		
MMR		
Polio		
Other:		

Does your child have any known environmental allergies? ______________________________

____

Please list any dietary restrictions: ______________________________

Does your child have any known food allergies / intolerances? ______________________________

____

Family History

Please indicate whether any of the child's family members have, or have had the following:

Condition	Relative	Condition	Relative
Alcoholism		Diabetes	
Allergies		Drug abuse	
Alzheimer's disease		Heart disease	
Arthritis		High blood pressure	
Asthma		Kidney disease	
Cancer (indicate type)		Osteoporosis	
Depression		Stroke	
Other mental illness		Suicide	

Does the child's mother or father have a chronic illness? What is their general state of health?

Mother ______________________________

____

Father ______________________________

____

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

____

____

Thank you very much for taking the time to complete this form.
It will greatly assist in the formulation of a treatment protocol specific to your child.