



Creating *Healthier* Lives

**CHILD INTAKE FORM
(Ages 10 & under)**

PERSONAL INFORMATION:

Name: _____ Date: _____

Address: _____

City/Prov: _____ Postal Code: _____

Telephone: Home: _____ Work: _____

Cell: _____

E-mail: _____

Date of Birth: _____ Age: ____ Sex: ____

Caregiver's Name: _____ Relationship: _____

Emergency Contact: _____ Phone Number: _____

How did you hear about The Nardella Clinic? _____

Siblings Names:

_____	Age: _____
_____	_____
_____	_____
_____	_____

Family MD/ Pediatrician: _____

Address: _____ Phone Number: _____

Midwife/Obstetrician (children under 2): _____

Address: _____ Phone Number: _____

PRENATAL HISTORY

Please indicate any conditions experienced by the mother of this child during pregnancy:

- | | | |
|---|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Edema (Swelling) | <input type="checkbox"/> Emotional Trauma |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> German measles | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Infections | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Physical Trauma |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Excessive Weight Gain | |
| <input type="checkbox"/> Pregnancy Induced Hypertension | Other: _____ | |

Please list supplements/medications taken by the mother during her pregnancy with this child: _____

Please indicate any of the following items this child's mother used during her pregnancy and frequency:

- | | |
|---|--|
| <input type="checkbox"/> Cigarettes _____/day | <input type="checkbox"/> Alcohol _____/week |
| <input type="checkbox"/> Caffeine _____/day | <input type="checkbox"/> Drugs (type) _____/week |

Was there any history of a complicated pregnancy before the birth of this child? _____

If yes, please describe: _____



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BIRTH HISTORY

Length of gestation _____ Length of labour _____

Was labour spontaneous? _____ If not, how was it induced? _____

Type of delivery: ___ Vaginal ___ C-section ___ Emergency C-section

Were there any interventions used during the birth of this child? ___ Yes ___ No

If yes, what type? _____

What was this child's weight at birth? _____

Were any of the following experienced at or soon after this child's birth?

- | | | |
|--|---|--|
| <input type="checkbox"/> Allergic reactions | <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Difficulty Feeding | <input type="checkbox"/> Fevers | <input type="checkbox"/> Failure to Thrive |
| <input type="checkbox"/> Hypoxia | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Seizures | <input type="checkbox"/> Unusual Weight Gain |
| <input type="checkbox"/> Unusual Weight Loss | <input type="checkbox"/> Respiratory Difficulties | |

Other: _____

When did these problems begin? _____

What treatments have you tried for this child's health concerns? _____

List any other health concerns regarding this child: _____

Did this child undergo any of the following interventions?

- | | | |
|---------------------------------------|-------------------------------------|----------------------------------|
| <input type="checkbox"/> Medications | <input type="checkbox"/> Respirator | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Billi-Lights | <input type="checkbox"/> Incubation | |

Please list any medications or supplements this child is taken or has taken:

Currently: _____

Has Taken: _____

CHILD'S HEALTH HISTORY

What is your major health concern regarding this child?

What other concerns do you have?

1. _____

2. _____

3. _____

Does the child sleep during the night? _____ Number of hours _____

What is the child's napping pattern during the day? _____

Does this child suffer nightmares? _____

Does this child have any known allergies? ___

If yes, what allergies?

Has this child ever been hospitalized? ___

If yes, when and what for? _____



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Please indicate any of the following that pertain to the child:

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Body/ Breath Odour |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Burning Urine | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Colds | <input type="checkbox"/> Constipation | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Cradle Cap | <input type="checkbox"/> Croup | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Easy Bleeding | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Emotional Trauma | <input type="checkbox"/> Eye Infections |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fever | <input type="checkbox"/> Fracture |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Fungal Infections | <input type="checkbox"/> Gas |
| <input type="checkbox"/> Growing Pains | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Lice | <input type="checkbox"/> Measles | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Mumps | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Nose Bleeds |

Please indicate any of the following that applies:

- | | | |
|---|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Physical Trauma | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rubella | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Stomach Flu | <input type="checkbox"/> Strep Throat | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Unusual Fears | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Walking difficulties | <input type="checkbox"/> Crawling Difficulties | <input type="checkbox"/> Whooping Cough |

FAMILY HISTORY

Mother's age at time of child's conception _____
 Father's age at time of child's conception _____
 Describe mother's health at time of child's conception _____
 Describe father's health at time of child's conception _____

Please mark a check by any of the following that pertain to the child's immediate family:

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Bleeding disorders |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Herpes | <input type="checkbox"/> HIV of AIDS |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Peptic Ulcer | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Visual Problems | | |

Other: _____

SOCIAL HISTORY

Describe this child's general temperament _____



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Describe this child's interaction with others _____
 Has this child experienced any emotional trauma? _____
 How does this child handle stress? _____
 How does this child express his or her emotions? _____
 How would you describe this child's performance at school? _____
 How do you feel other people would describe this child? _____
 Have you ever noticed any behavioral problems with this child while at school/daycare/sitters? If yes, please describe:

 Does this child take part in any extracurricular activities? _____ If yes, please describe:

IMMUNIZATION HISTORY

Please indicate approximate dates where relevant:

Measles _____	Mumps _____	Rubella _____
Polio _____	Small Pox _____	Influenza _____
Hepatitis _____	Chicken Pox _____	Diphtheria _____
Pertussis _____	Tetanus _____	Other _____

Please indicate any of the following adverse or odd reactions that this child may have experienced after receiving his/her immunizations:

<input type="checkbox"/> Swelling	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Limping
<input type="checkbox"/> Mood Changes	<input type="checkbox"/> Rash	<input type="checkbox"/> Fever
<input type="checkbox"/> Excessive Crying	<input type="checkbox"/> Pain	<input type="checkbox"/> Loss of Appetite
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Insomnia	
Other _____		

NUTRITIONAL HISTORY

Was this child breastfed? _____ If yes, for how long? _____
 If no, please indicate what food and brand was used _____
 Excluding water and breast milk, what was the first liquid introduced to this child?

Please list solid food items in the order they were introduced to this child:

Food	Age of Introduction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Were any adverse reactions to these above foods or any other foods noticed?
 If yes, what were these foods? _____

Is this child a vegetarian? _____
 How would you describe this child's eating habits? _____
 Please give a rough outline of this child's daily diet:



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Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Water Intake: _____
Other Fluids: _____
Nutritional Supplements: _____

HOME ENVIRONMENT

How many people live in the same home as this child? _____
Are there any smokers in the same house as the child? _____
Are there any pets in the same house as the child? _____
How old is the home this child lives in? _____
How would you describe the emotional environment in which this child lives?

Please add any additional information you feel would be helpful regarding this child.

Signature of Parent or Guardian

Date

INFORMED CONSENT

The above information is true to the best of my knowledge. I understand that I am financially responsible for payment, upon service rendered. I also authorize The Nardella Clinic to release information required by my extended health care provider to process my claims. I acknowledge that I must give 48 hours notice for any cancellation or rescheduling of a booked appointment. If said notice is not given I acknowledge that a cancellation fee will be applied to the Credit Card number that I have provided at the time of initial booking.

Patient/Guardian signature