



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 these health concerns? \_\_\_\_\_

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 |                                  |

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? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

Currently: \_\_\_\_\_

Has Taken: \_\_\_\_\_



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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



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Describe this child's general temperament \_\_\_\_\_  
 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? \_\_\_\_\_  
 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 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? \_\_\_\_\_

\_\_\_\_\_

Does this child have any dietary restrictions? (ex: Religious, vegan, vegetarian)

\_\_\_\_\_



**HOME ENVIRONMENT**

How many people live in the same home as this child? \_\_\_\_\_

Is the child exposed to any of the following at home: \_\_\_\_\_ Smoking

\_\_\_\_\_ Pets

How old is the home this child lives in? \_\_\_\_\_

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**

I would like to take this opportunity to welcome you to the clinic. This Clinic utilizes the principles and practices of Naturopathic Medicine and supplemental therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.

Your practitioner will conduct a thorough case history, which may include a physical exam and specific laboratory testing as part of the treatment. Any practitioner you choose to work with will have access to your history to minimize repetition while maintaining complete confidentiality.

**Statement of Acknowledgement**

I, (printed name) \_\_\_\_\_ as a patient of this clinic, have read the information and understand that the form of medical care is based on Naturopathic and other supportive principles and practices. As the clinic is an integrated health clinic, I recognize that all the practitioners that are working with me will have access to my file. I also recognize that even the gentlest of therapies potentially have their complications in certain physiological conditions, in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but are not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs, pain, fainting, bruising or injury from venipuncture or acupuncture; and muscle strains and sprains.



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I also confirm that I have the ability to accept or reject this care of my own free will and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so declaring.

I understand that, as a patient, I am responsible for all costs incurred as a result of the decision including, but not limited to; the cost of all procedures involved in the treatment plan, the care provider's time, supplements, supplies and appointments missed or cancelled without sufficient notice (48 hours). I am aware that treatments are not covered through Alberta Health Care and may not be covered under private health insurance.

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\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date