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# Naturopathic Children’s Intake Form

**Dr. Caitlin Shea, Naturopathic Doctor**

**Patient Information To be Completed by Parent/Guardian**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: (D): \_\_\_\_\_\_\_ (M):\_\_\_\_\_\_ (Y): \_\_\_\_\_\_ Age: \_\_\_\_\_\_

Preferred Pronoun He She Other: \_\_\_\_\_\_\_

Phone (home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (business): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (mobile): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ e-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we leave a message relating to your visit? Y / N

How did you hear about the Clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father’ name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s Occupations: Mother \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other health care providers your child is seeing:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_

Date of last visit: \_\_\_\_\_\_\_\_\_\_\_ Date of last visit: \_\_\_\_\_\_\_\_\_\_\_ Date of last visit: \_\_\_\_\_\_\_\_\_\_\_

**Health Goals**

Please state child’s primary reason for attending our clinic. Please list the first time you noticed the condition and describe any factors that you suspect may have played a role in its onset and perpetuation.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list any other health concerns/complaints:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list past health problems and dates:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medical History**

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the child have any allergies (Medicines, environmental, etc.)?

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all current medications/natural health products (prescription, over-the-counter, vitamins, herbs, etc.)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list past prescription medications/natural health products:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please indicate what immunizations your child has had:

 DPT (diptheria, pertussis, tetanus)  Haemophilus influenza B  Pneumococcal Conjugate (meningitis)

 Hepatitis B  MMR (measles, mumps, rubella)  Polio

Please indicate if any caused adverse reactions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal and Family History**

Please indicate if this condition applies to your child or one of your family members and indicate who the condition applies to (Your child, Father, Mother, Sibling, Grandparent). Indicate if the condition is Resolved or Current.

|  |  |  |  |
| --- | --- | --- | --- |
| Cancer |   | Heart disease |   |
| Allergies |   | Osteoarthritis |   |
| Diabetes |   | Rheumatoid Arthritis |   |
| Multiple Sclerosis |  | Mental Illness |  |
| Asthma |  | Psoriasis |  |
| Eczema |  | Alcoholism  |  |

**Diet**

Does your child have any food allergies or intolerances? Please list.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was your child breastfed? Y / N

**Review of Systems**

Please check off any condition that your child has experienced in the past or present. Make a **√** for current, **X** for past:

|  |  |  |
| --- | --- | --- |
|  Hives  Eczema  Acne  Chronic Rash  Easy Bruising  Excessive Fatigue Sore Throats Frequent Colds Canker Sores High Fevers  Dizzy Spells Anemia |  Cough Burning Urination Stomach Aches Constipation Diarrhea Gas No Appetite Vomiting Spells Bleeding Gums Jaundice Nose Bleeds Wheezing |  Cries Easily Unusual Fears Night Sweats Sensitive to Light Body/Breath Odour Motion/Car Sickness Frequent Headaches Joint Pains Flat Feet Hearing Loss Heart Murmur  |

Is there anything that you feel is important that has not been covered?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Consent to Treat a Minor:**

As the parent/guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (child’s name), I hereby authorize Caitlin Shea N.D to treat \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (child’s name), according to the assessment and treatment program outlined by Caitlin Shea N.D.

Parent/Guardian signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_