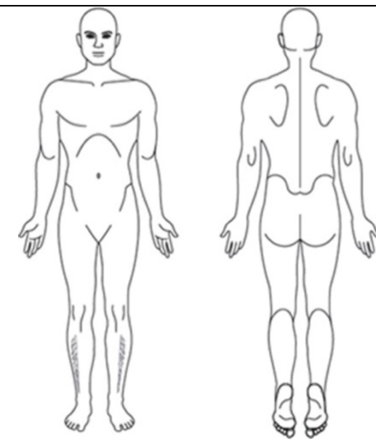
ALL SYSTEMS
WELLNESS + CHIROPRACTIC + NATUROPATHY

CHILD NATUROPATHIC INTAKE FORM

Full Name:		Date of birth:
Parent/Guardian's Name:		
Home Phone Number:		Cell Phone Number:
Address:		
City:	Postal Code:	Province:
Email Address:		
Name of Emergency Contact:		Number:
How did you hear about the clinic:		

Health Goals

Please list the patient's important health concerns and goals in their order of significance	**Indicate the painful or distressed area if applicable**
1.	
2.	
3.	
4.	
5.	

Medical History

Please indicate any serious conditions, illness or injuries, or (hospitalizations, along with approximate date.

Please list any allergies the patient has (medications, foods, environmental etc…)

Please list all current and previous **medications** and **natural health products** the child is taking (prescription, over the counter, vitamins, herbs, homeopathics etc…)

Full Name: ____________________________________

Immunization: Please check any vaccinations the child has received and any reactions that followed

MMR Reactions______________ DPT Reactions**:**____________
HepB Reactions______________ Chickenpox Reactions:____________
Influenza (Hib) Reactions _____________ Polio Reactions**:**_____________

Please mark "**C**" for current, "**P**" for past, "**B**" for both if the child has experienced any of the following:

Allergies		Frequent Colds		Headaches	
Influenza		Chicken Pox		Bed Wetting	
Asthma		Measles		Mumps	
Food Sensitivities		Rashes/Hives		Pneumonia	
Diarrhea		Constipation		Jaundice	
Ear Infections		Fractures		Bladder Infections	

Family History

Please indicate family member to which the history applies

Allergies		Heart Disease	
Multiple Sclerosis		Multiple Dystrophy	
Asthma		High Blood Pressure	
Eczema		Kidney Disease	
Cancer		Mental Illness	
Seizures		Cerebral Palsy	
Endocrine Disease		Migraines	
SIDS		Mentally Handicap	
Diabetes		Depression	

Are parents divorced or separated? Y_____ N_____

If yes, whom does the child live with? __________

Neonatal History: Please check any that apply

- ☐ Jaundice
- ☐ Colic
- ☐ Respiratory Problems
- ☐ Heart problems
- ☐ Clef palate/lip
- ☐ Spina bifida
- ☐ Scoliosis
- ☐ Cataracts/Glaucoma
- ☐ Hip problems

Other ____________________________________

What are the child's interests?

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Do you consent to a professional & complete naturopathic examination?

Signature ____________________________________ Date ___________________