Nardella
Creating Healthier Lives

CHILD INTAKE FORM
(Ages 10 & under)

PERSONAL INFORMATION:

Name: _____ Date: _____
Address: _____ City: _____ Province: _____
Postal Code: _____
Telephone: Home: _____ Cell: _____ Work: _____
E-mail: _____
Date of Birth: _____ Age: ___ Sex: ___

Caregiver's Name(s): _____ Relationship: _____
Emergency Contact: _____ Phone Number: _____

Do you have extended health insurance? __ Yes __ No
If yes, please list provider: _____

How did you hear about The Nardella Clinic? _____

I would like to be on the clinic's general mailing list to receive clinic information, such as subscriber specials and the clinic newsletter. Please circle YES/NO.

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:

___ Diabetes ___ Edema (Swelling) ___ Emotional Trauma
___ Fainting ___ German measles ___ Herpes
___ Hypertension ___ Infections ___ Nausea
___ Vomiting ___ Thyroid Problems ___ Physical Trauma
___ Weight loss ___ Excessive Weight Gain
___ 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:

__ Cigarettes _____/day __ Alcohol _____/week
__ Caffeine _____/day __ Drugs (type) _____/week

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Was there any history of a complicated pregnancy before the birth of this child? _____
If yes, please describe:
_____

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?

__ Allergic reactions	__ Birth Defects	__ Colic
__ Difficulty Feeding	__ Fevers	__ Failure to Thrive
__ Hypoxia	__ Jaundice	__ Meningitis
__ Rashes	__ Seizures	__ Unusual Weight Gain
__ Unusual Weight Loss	__ 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?

__ Medications	__ Respirator	__ Surgery
__ Billi-Lights	__ 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 taking or has taken:
Currently: _____
Has Taken: _____

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

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

Please indicate any of the following that applies:

__ Pneumonia	__ Physical Trauma	__ Rash
__ Rheumatic Fever	__ Rubella	__ Scarlet Fever
__ Seizures	__ Sleeping Problems	__ Sore Throat
__ Stomach Flu	__ Strep Throat	__ Tonsillitis
__ Unusual Fears	__ Vision Problems	__ Vomiting
__ Walking difficulties	__ Crawling Difficulties	__ 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:

___ Allergies	___ Arthritis	___ Asthma
___ Autoimmune Disease	___ Birth Defects	___ Bleeding disorders
___ Cancer	___ Hearing loss	___ Depression
___ Diabetes	___ Eczema	___ Heart Disease
___ Hepatitis	___ Herpes	___ HIV or AIDS
___ Hypertension	___ Kidney Disease	___ Mental Illness
___ Peptic Ulcer	___ Thyroid Disease	___ Tuberculosis
___ Visual Problems		

Other: _____

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SOCIAL HISTORY

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:

___ Swelling	___ Joint Pain	___ Limping
___ Mood Changes	___ Rash	___ Fever
___ Excessive Crying	___ Pain	___ Loss of Appetite
___ Vomiting	___ 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? _____
_____

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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.

_____

_____

_____

_____

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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 of parent/guardian) _____ , 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.

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 all telemedicine appointments will be charged to the credit card on file seven (7) days in advance of the appointment. I am aware that treatments are not covered through Alberta Health Care and may not be covered under private health insurance.

_____ _____

Signature of Parent or Guardian Date

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