Child Intake Form

Welcome to Zawada Health, where the health of your family is our priority. Offering the services of Naturopathic Doctors, Registered Massage Therapists, an Osteopathic Manual Practitioner and a full product dispensary, we develop customized wellness plans for each member of your family. Using traditional wisdom and modern research, we strive to provide you with safe and effective solutions that fit your lifestyle.

Name: ____
(Last) *(First)* *(Preferred name)*

Height: ______________ *Weight:* ______________ *Age:* ______________

DOB: _____ /_____ / _____ *Sex:* ______________

Is your child currently (or has s/he previously been) under the care of an alternative healthcare provider (e.g. naturopathic doctor, acupuncturist, homeopath, chiropractor)? ☐ Yes ☐ No

If so, please specify. ____

Please list you child's chief health concerns in order of importance:

1. ____
2. ____
3. ____

Please list all medications (prescription, over-the-counter) and natural products (vitamins, herbs, oils) currently taking – including the daily dose/quantity and reason for taking the product.

Please list any past medications your child has been prescribed – including the daily dose/quantity and reason for taking the product.

How many times has your child been treated with antibiotics? ____________________

Has your child ever experienced adverse effects or an allergic reaction to any of the above products? ☐ Yes ☐ No

If so, please specify. ____

Please list any allergies or sensitivities (food/environmental, medications) you currently have or have had previously

Please list all hospitalizations, surgeries and/or major injuries you have experienced, including the year, outcome and any complications.

Please check off any condition(s) your child currently or has previously experienced.

☐ Rubella	☐ Roseola	☐ Chicken pox	☐ Mumps
☐ Measles	☐ Scarlet fever	☐ Whooping cough	☐ Strep throat
☐ Impetigo	☐ Mononucleosis	☐ Ear infections	

Please check off any of the following immunizations your child has had.

☐ Chicken pox (varicella)	☐ Influenza (flu)	☐ Hep A
☐ MMR (measles/mumps/rubella)	☐ Meningitis	☐ Hep B
☐ Tetanus booster; when? ____________	☐ DTP (diphtheria)	☐ Polio
☐ HIB (haemophilus influenza B)	☐ Other, please specify: ______________________________	

Did your child experience any adverse effects following any of these immunizations? ____________________________________

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Prenatal Health

How was the health of the parents at conception? Please specify any relevant health conditions.

Mother: ____

Father: ____

How was the health of the mother during the pregnancy? Please specify any relevant health conditions.

What was the mother's age at the child's birth? ____________________

How was the mother's diet during pregnancy?
□ Poor □ Fair □ Good □ Excellent □ Unknown

Did the mother experience prenatal medical care? □ Yes □ No

Did the mother experience any of the following during the pregnancy?
□ Bleeding □ High blood pressure □ Nausea
□ Diabetes □ Thyroid problems □ Physical or emotional trauma
□ Vomiting □ Other, please specify: ____

Did the mother use any of the following substances during pregnancy?
□ Tobacco
□ Alcohol
□ Recreational drugs: ____
□ Prescription medications: ____
□ Over-the-counter medications: ____
□ Supplements: ____
□ Other: ____

Birth History
Term Length: □ Full □ Premature: _______ weeks □ Late: _______ weeks

Type of Birth: □ Vaginal □ C-section □ Induced □ Forceps □ Anesthesia Used

Length of Labour: _____________ Any complications? Please specify: ____

Did the child experience any of the following at or shortly after birth?
□ Jaundice □ Rashes □ Nausea
□ Birth injuries, please specify: ____
□ Birth defects, please specify: ____
□ Other, please specify: ____

Health & Development
At what age did your child first:
Sit up: _____________________ *Crawl:* _____________________ *Walk:* _____________________
Talk: ______________________ *Show Teeth:* ______________

Describe your child's: *Sleep pattern:* ____
Temperament: ____
Behaviour & School Performance: ____

Diet
How was your child first fed, and for how long?
□ *Breast milk:* ____
□ *Formula: Cow/Goat/Soy milk* ______________________________
□ *Other:* ____

Did your child ever experience colic? □ Yes □ No
If so, please the severity. □ Mild □ Moderate □ Severe

Does your child have any dietary restrictions? □ Yes □ No
If so, please specify ((e.g. vegan, religious, allergies) ____________________________

Food Introduction

Age	Food(s) Introduced – *Please specify approximate month*
Before 6 Months	
6-12 Months	

Typical Daily Diet

Breakfast	Lunch	Dinner	Snacks	Beverages (and total quantity)

Do either of the parents have a chronic illness? ☐ Yes ☐ No

If so, please specify. ____

	Age (or age at death)	Health Concerns
Mother		
Father		
Sisters		
Brothers		
Grandparents		

Environment

Does the child attend: ☐ School ☐ Daycare ☐ Homecare ☐ Other: ____________________________

What are your child's favourite activities? ____

Does the child regularly exercise? ☐ Yes ☐ No

If so, please specify. ____

How much television does your child watch per week? ____

How often does your child read (not for school), or is read to by someone?

☐ Daily
☐ Several times per week
☐ Weekly
☐ Less than weekly

How would you describe the emotional climate of the child's home: ____

Toxin Exposure

Does anyone in your child's household smoke? ☐ Yes ☐ No

Are there any animals in your child's home? ☐ Yes ☐ No

Has your child ever been exposed to mold, solvents, lead paint, heavy metals, fumes or other toxic substances at home or school, or while traveling? ☐ Yes ☐ No

Has your child ever experienced health problems after putting down new carpeting, painting your home, doing renovations or having your lawn sprayed with herbicide? ☐ Yes ☐ No

Is your child particularly sensitive to perfume, gasoline, or other vapors? ☐ Yes ☐ No

Has your child ever lived near a refinery or a polluted area? ☐ Yes ☐ No

Has your child ever lived in a home more than 50 years old? ☐ Yes ☐ No

Do you believe your child has ever been exposed to mercury (i.e. playground, dental fillings)? ☐ Yes ☐ No

Does your child have any surgical implants (cosmetic, medical)? ☐ Yes ☐ No

Does your child live near power lines? ☐ Yes ☐ No

Review of Systems

Please indicate any condition(s) that your child is currently or has previously experienced for each body system.

Body System	Condition
Skin (i.e. excema, psoriasis, hives, rashes)	
Head (i.e. headaches)	
Eyes (i.e. itching, pain, infection, corrective lenses)	
Ears (i.e. wax, discharge, hearing impairment)	
Nose (i.e. sinus problems, pain, nose bleeds)	
Mouth (i.e. difficult dentition, cavities, loss of taste, problems swallowing)	
Neck (i.e. stiffness, tenderness, hoarseness, tonsillitis, swelling)	
Heart (i.e. rheumatic fever, murmurs, chest pain)	
Neurological (i.e. seizures, paralysis, clumsiness, memory, vision changes, speech problems, sensation alteration)	

Lungs (i.e. cough, asthma, wheezing)	
Gastrointestinal (i.e. vomiting, swallowing, diarrhea, constipation)	
Urinary (i.e. pain, increased frequency, blood)	
Male Reproductive (i.e. hernias, pain or masses in scrotum/testes)	
Female Reproductive (i.e. urgency, menstruation/menses, discharge, pain or masses in ovaries/uterus)	
Musculoskeletal (i.e. joint pain, stiffness, weakness, back pain, fractures)	

Is there anything you feel is important to note that has not been covered in this questionnaire?

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Thank you for answering all the questions.
Complete answers to all of the questions are to your benefit for the most effective naturopathic treatment.

This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.