



Vitality for Life
 HEALTH CENTER
 560 Bryne dr. Unit 1A
 Barrie, ON L4N 9P6
 705.733.2033
 www.vitalityforlife.ca

Child Intake Form

Please fill out this form to the best of your ability. It will help to assess your child's present health and will assist in facilitating the healing process.

Preferred First Name: _____ Last Name: _____

Age: _____ Height: _____ Weight: _____

What are your child's health concerns, in order of importance?

- 1.
- 2.
- 3.

How would you describe your child's general state of health?

Excellent Good Fair Poor

Does your child have any allergies (medicines, environmental, etc.)? _____

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

Which of the following has your child had? (n - never, m - mild, a - average, s - severe)

n	m	a	s	rubella (german measles)	n	m	a	s	roseola
n	m	a	s	measles	n	m	a	s	scarlet fever
n	m	a	s	chicken pox	n	m	a	s	mumps
n	m	a	s	whooping cough	n	m	a	s	strep throat
n	m	a	s	impetigo	n	m	a	s	mononucleosis
n	m	a	s	ear infections					

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics).

Please list past prescription medications. -----

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

Please indicate what immunizations your child has had.

- Chicken pox (varicella) Influenza (flu)
- MMR (measles/mumps/rubella) Meningococcal (meningitis)
- DTP (diphtheria) Polio
- Tetanus booster; when? ----- Hep A
- Haemophilus influenza B Hep B

Other -----

Please indicate if any caused adverse reactions.

What screening tests has your child had (blood, hearing, vision, etc.)? -----

PRENATAL HEALTH

What was the health of the parents at conception?

Mother -	Poor	Fair	Good	Excellent	Unknown
Father -	Poor	Fair	Good	Excellent	Unknown

What was the health of the mother during the pregnancy?

Poor	Fair	Good	Excellent	Unknown
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What was the mother's age at child's birth? -----

How was the mother's diet during pregnancy?

Poor	Fair	Good	Excellent	Unknown
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Did the mother receive prenatal medical care? Yes No Unknown

Did the mother experience any of the following during the pregnancy?

- Bleeding High blood pressure Nausea Vomiting Diabetes
- Thyroid Problems Physical or emotional trauma Other -----

Did the mother use any of the following during pregnancy?

- Tobacco Alcohol Recreational drugs: _____
 - Prescription medications: _____
 - Over-the-counter medications: _____
 - Supplements: _____
 - Other: _____
-

BIRTH HISTORY

Term length: Full Premature: _____ wks Late: _____ wks

Length of Labour: _____ Weight at birth: _____

Any complications? _____

Was the birth: Vaginal/C-Section Induced Forceps Anesthesia used

Did the child experience any of the following at or shortly after birth?

- Jaundice Rashes Seizures Birth injuries _____
 - Birth defects _____
 - Other _____
-

DIET

How was your infant fed?

- Breast milk. How long? _____ Formula: Cow'/Goat/Soy milk. _____
- Other: _____

What foods were introduced before six months? (Please list approximate month.)

6 - 12 months?

Did your child experience colic? Y N

How severe was the colic? mild moderate severe

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

Does your child have any dietary restrictions (religious, vegetarian, vegan, etc.)?

Describe a typical day's diet.

Breakfast -----
Lunch -----
Dinner -----
Snacks -----
Beverages (and total quantity) -----

HEALTH AND DEVELOPMENT

How was your child's health in the first year? Poor Fair Good Excellent Unknown

At what age did your child first:

Sit up ----- Crawl ----- Walk ----- Talk ----- Show teeth -----

Describe your child's sleep pattern. -----

How would you describe your child's temperament? -----

How would you describe your child's behaviour and performance at school?

FAMILY HISTORY

Indicate if a close relative (parent, sibling) has had any of the following:

	Who?		Who?
Allergies		Diabetes	
Asthma		Kidney disorder	
Birth defects		Other	
Juvenile arthritis			

I don't know the family history

Do either of the parents have a chronic illness? Y N Please describe -----

ENVIRONMENT

Is the child in: school daycare home care other _____

What are you child's favourite activities? _____

Does the child exercise regularly? Y N How much, how often? _____

How much television does your child watch? _____ hours

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

- daily
- several times a week
- weekly
- less than weekly

Does anyone in the child's household smoke: Y N

Are there any animals in the home? Y N

How is the child's home heated? _____

Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)? Please describe:

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

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

