Live Well Osteopathy & Massage Therapy
Karen Maloney-Younker ND

Child Intake Form

Name: _____ Date: _____

Date of Birth: _____ (Month/Day/Year)

Address: _____ Apt/Unit #: _____

City: _____ Province: _____ Postal Code: _____

Parent's Email Address: _____

Telephone Number: Home: _____ Work: _____ Cell: _____

Preferred number at which to be contacted _____

Emergency contact: Name: _____

Phone number: _____ or _____ Relation: _____

Other health care providers you're child is seeing (MD, osteopath, etc):

Name: _____ Name: _____ Name: _____

Specialty: _____ Specialty: _____ Specialty: _____

Phone #: _____ Phone #: _____ Phone #: _____

Date of last visit: _____ Date of last visit: _____ Date of last visit: _____

Have you previously consulted with a Naturopathic Doctor? _____

What are your health concerns/goals?

1. _____
2. _____
3. _____
4. _____
5. _____

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Medical History

Please circle Yes (Y), No (N) or Past (P) regarding use of the following:

Aspirin, Tylenol, Advil or other pain relievers Y N P
Antibiotics Y N P Approximate number of prescriptions: _____
Other
medications:_____
_____
Supplements (vitamins,
etc):_____
_____

Please indicate what immunizations your child has had (please check):

Diphtheria, Tetanus, Pertussis (DTaP)/Haemophilus influenza B (Hib)/Polio (IPV); (this group is usually given together at 2, 4 and 6 months):_____
MMR (measles, mumps, rubella)/Varicella (chicken pox); (may be given together or separately usually 12-18 months and 4-6 years):_____
Rotavirus:_____
Meningicoccal:_____
Pneumococcal:_____
Hepatitis B:_____
Human Papilloma Virus (HPV):_____
Influenza (flu):_____
Other _____

Please indicate if any caused adverse reactions:
_____
_____
_____

Diet

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

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

Breast fed? If so, how long?
_____

Introduction of solids at what age? Any difficulties?

_____

_____

Personal and Family History

Please check the "yes" box next to each condition that applies to you and/or one of your family members. Please circle all whom the condition applies to: "Self" if it relates to you and/or Father (F), mother (M), sibling (S), Grandparent (G).
Please circle Past if the condition is resolved, or Current if it is on-going and current

	Yes	Relation (Please circle)	Date		Yes	Relation (Please circle)	Date
Alcoholism/ Drug Addiction		Self F M S G	Past /Current	High Blood Pressure		Self F M S G	Past /Current
Allergies		Self F M S G	Past /Current	Heart Disease		Self F M S G	Past /Current
Anemia		Self F M S G	Past /Current	Hepatitis		Self F M S G	Past /Current
Arthritis		Self F M S G	Past /Current	Headaches		Self F M S G	Past /Current
Asthma		Self F M S G	Past /Current	Osteoporosis		Self F M S G	Past /Current
Cancer		Self F M S G	Past /Current	Kidney Disease		Self F M S G	Past /Current
Diabetes		Self F M S G	Past /Current	Stroke		Self F M S G	Past /Current
Eczema		Self F M S G	Past /Current	Tuberculosis		Self F M S G	Past /Current
Epilepsy		Self F M S G	Past /Current			Self F M S G	Past /Current
Depression/ Mental Illness		Self F M S G	Past /Current	Others:		Self F M S G	Past /Current

Environment
Is your child regularly physically active? Y / N
Sports and extracurricular activities:

_____

_____

_____

Interests:

_____

_____

_____

Is your child exposed to significant tobacco smoke? Y / N
Is your child frequently exposed to animals (farm, pets, etc.)? Y / N
How is the home heated?_____

Has your child ever been exposed to solvents, heavy metals, fumes pesticides/herbicides or other toxic materials (school, home, hobbies, etc.)? Please describe:

_____
_____
_____

Is your child particularly sensitive to perfumes, gasoline or other vapours (such as from new furniture, carpets, paints etc)? _____

How stressful is school, home or other aspects of your child's life? How well does your child handle these stresses?

_____
_____
_____

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

_____
_____
_____