

Child Naturopathic Intake Form

Please complete this form for any child less than 14 years of age

This is a confidential record of your information and medical history that will be kept by Dr. Natasha Zajmalowski ND. Information contained in it will not be released to any person unless you authorize us to do so. Thank you in advance for taking the time to fill out this questionnaire. It will help to ensure the clinic has an understanding of your present health concerns and your health goals. This information will assist in the choosing of the individual treatment plan that will guide you to your optimal health.

Child's Name:

Male/Female:

Age:

Birth date:

Adopted: Y N

Parent/Guardian/Caretaker Name:

Address:

City:

Province:

Postal Code:

Phone# (Home):

(Bus):

(Cell):

Email:

Emergency Contact Name:

Phone#:

Relation:

What is your Naturopathic Health Coverage?

How did you hear about this clinic: Radio, Phonebook, Driving by, Website, Family, Friends or Referral (Please share who because we have a referral appreciation program and would like to thank them)

Is there anything regarding the child that should not be mentioned in his/her presence?

CURRENT HEALTH

Please list your child's major health concerns in order of importance:

- 1. \_\_\_\_\_  
(Complaint) (Duration) (Possible Causes)
- 2. \_\_\_\_\_  
(Complaint) (Duration) (Possible Causes)
- 3. \_\_\_\_\_  
(Complaint) (Duration) (Possible Causes)
- 4. \_\_\_\_\_  
(Complaint) (Duration) (Possible Causes)

Please list any current MEDICATIONS (prescription, over-the-counter, etc.):

- 1. \_\_\_\_\_  
(Medication) (Duration) (Adverse Effects, if any)
- 2. \_\_\_\_\_  
(Medication) (Duration) (Adverse Effects, if any)
- 3. \_\_\_\_\_  
(Medication) (Duration) (Adverse Effects, if any)
- 4. \_\_\_\_\_  
(Medication) (Duration) (Adverse Effects, if any)
- 5. \_\_\_\_\_  
(Medication) (Duration) (Adverse Effects, if any)
- 6. \_\_\_\_\_  
(Medication) (Duration) (Adverse Effects, if any)
- 7. \_\_\_\_\_  
(Medication) (Duration) (Adverse Effects, if any)
- 8. \_\_\_\_\_  
(Medication) (Duration) (Adverse Effects, if any)

Please list any current SUPPLEMENTS (vitamins, minerals, herbs, etc.)

- 1. \_\_\_\_\_  
(Supplement) (Duration) (Adverse Effects, if any)
- 2. \_\_\_\_\_  
(Supplement) (Duration) (Adverse Effects, if any)
- 3. \_\_\_\_\_  
(Supplement) (Duration) (Adverse Effects, if any)
- 4. \_\_\_\_\_  
(Supplement) (Duration) (Adverse Effects, if any)

5. \_\_\_\_\_  
(Supplement) (Duration) (Adverse Effects, if any)

6. \_\_\_\_\_  
(Supplement) (Duration) (Adverse Effects, if any)

Diet:

Please describe your child's typical day's diet:  
Breakfast:

Lunch:

Dinner:

Snacks:

List any known food allergies or intolerances:

List any special diet followed (ex. vegetarian, vegan etc.):

List any cravings the child has or food they ask for? (ex. bread, cookies)?

List any aversions the child has (ex. won't eat meat):

What percent of your child's diet is organic? What types of food (ex. fruit, veggies, meat, dairy)?

What is the source of your water (ex. tap, well, bottled spring, reverse osmosis, distilled, etc)?

Please indicate if your child consumes/uses any of the following.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Candy          | <input type="checkbox"/> Microwave to heat food     | <input type="checkbox"/> Artificial sweeteners |
| <input type="checkbox"/> Chocolate      | <input type="checkbox"/> Microwave dinners          | <input type="checkbox"/> Margarine             |
| <input type="checkbox"/> Desserts       | <input type="checkbox"/> Prepackaged food (ex. M&M) | <input type="checkbox"/> Salt                  |
| <input type="checkbox"/> Fast food      | <input type="checkbox"/> Antacids                   | <input type="checkbox"/> Lake fish             |
| <input type="checkbox"/> Luncheon Meats |   | <input type="checkbox"/> Beef                  |
| <input type="checkbox"/> Fried foods    |   | <input type="checkbox"/> Pork                  |
| <input type="checkbox"/> Plastic wrap   |   |  |

Dr. Natasha Zajmalowski ND: Proactive Health Care

- Processed cheese
- Canned food
- White bread
- White pasta
- Chips
- Hot dogs

How many of the following does your child drink on average/day?

Coffee

Tea

Water

Herbal Tea

Milk (what %)

Fruit Juice

Diet pop

Regular pop

Crystal Light/ diet drink

Veggie Juice

Protein Shake





## SYMPTOMS

Please check what applies to your child presently. Write P for any symptom he/she experienced in the past.

### Skin

- o Temperature change
- o Moisture change
- o Colour change
- o Itching
- o Pain
- o Rashes
- o Lumps
- o Moles
- o Infections
- o Eczema
- o Hives
- o Moles
- o Other:

### Hair/Nails

- o Falling out
- o Oil
- o Dry
- o Peeling and Brittle nails
- o Pitting nails
- o Ridges
- o White Lines

### Head

- o Headache
- o Migraines
- o Injury/Concussion

### Eyes

- o Itching
- o Tearing
- o Dryness
- o Pain

- o Redness
- o Infections
- o Discharge
- o Glasses
- o Dark circles under eyes

### Ears

- o Impaired hearing
- o Pain
- o Dizziness
- o Discharge
- o Infections

### Nose and Sinus

- o Runny Nose
- o Stuffiness
- o Nosebleeds
- o Mouth Breather due to stuffiness

### Mouth and Throat

- o Cold sores
- o Canker sores
- o Cavities
- o Difficulty speaking
- o Difficulty swallowing
- o Throat infections
- o Bites nails

### Respiratory

- o Cough
- o Phlegm
- o Wheezing
- o Shortness of Breath

- o Asthma
- o Puffers

### Heart

- o Murmurs
- o Heart Abnormalities

### Gastrointestinal

- o Bloating
- o Belching/Passing Gas
- o Abdominal Pain
- o Diarrhea
- o Constipation
- o Hernia
- o Worms/Parasites

### Urinary

- o Bladder infections
- o Bed-wetting
- o Pain on urination

### Male

- o Un-descended testes
- o Circumcised
- o Testicular masses

### Female

- o Discharge
- o Itching

### Musculoskeletal

- o Fractures
- o Joint swelling
- o Muscle spasms
- o Weakness

## PRENATAL HEALTH

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

Bleeding

Edema

Physical trauma

Pre-mature labour

Diabetes

Emotional trauma

High blood pressure

Thyroid issues

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

How was the mother's diet during pregnancy?

Poor Fair Good Excellent Unknown

Any cravings?

Any aversions?

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

Tobacco

Alcohol

Recreational drugs

Prescription meds  
OTC meds

Supplements  
Other:

Were there any new events/changes/symptoms/conditions that occurred during pregnancy?

### BIRTH HISTORY

Full term:

Premature (how many weeks?):

Late (how many weeks):

Weight (lbs):

Length of labour(hrs)

Any complications:

- Vaginal
- C-section
- Induced
- Forceps
- Episiotomy
- Home birth
- Hospital Birth
- Midwife

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

- Jaundice
- Rashes
- Seizures
- Birth injuries
- Projectile vomiting
- Birth defects

How was the infant fed?

Breastfed (how many months?):

Formula (when was it started?):

Type:

What foods were introduced before 6 months and in what order?

What foods were introduced between 6-12months?

Did your child ever experience colic?

Please use the remainder of the space provided to write anything else you feel the doctor should know about your child.