Cross Roads Naturopathic Medicine
350-507 West Broadway Avenue, Vancouver, BC
604-568-6899

Children's Intake Form – please fill in for children up to 12 years of age
Please complete the following form as thoroughly as possible. All information is confidential.

Name: ____________________________ Today's Date: _________________________

Address:____________________________ City: _______________________________

Province: ___________________________ Postal Code: __________________________

Phone: (h)__________________________ Phone: (cell) __________________________

E-mail: _____________________________ Date of Birth: _________________________

Care Card / Personal Health Number:____

Parent's / Guardian's names: ____

Emergency Contact Person:________________________ Phone:___________________________

Family Doctor's or medical clinic address/phone:

____

Date of last visit to Doctor/Clinic:____

Has your child had the routine check-ups as recommended by their health care provider?

____

Is your child under the care of a medical specialist? Y______ N______

Name/specialty: ____

Health Concerns – Please list:

1. ___________________________ 4. ______________________________
2. ___________________________ 5. ______________________________
3. ___________________________ 6. ______________________________

Does your child have any life threatening allergies? Y______ (list below) N______

____

Please list any over the counter or prescribed medications and/or vitamins/supplements (include dosage)

_________________________________ ___________________________________

_________________________________ ___________________________________

_________________________________ ___________________________________

How did you hear about our clinic? ____

Past Medical History

Please check if your child has concerns with any of the below:

SKIN

Hives	______	Itching	______
Rash	______	Excessive dryness	______
Cradle Cap	______	Swollen Glands	______
Excessive sweating	______		

ALLERGIES

Seasonal Allergies	______	Hay fever	______

MOUTH/GUMS

Sore throat	______	Gum problems	______
Teething pain	______	Canker sores	______
Cold sores	______	Cracked lips	______
Removal of Tonsils	______	Thumb sucking	______

GENERAL

Fainting	______	Seizures	______
Vision problems	______	Pink Eye (conjunctivitis)	______
Shortness of breath	______	Wheezing	______
Cough	______	Stutter/Lisp speech	______
Excessive appetite	______	Picky eater	______
Spitting up frequently	______	Acid Reflux	______
Stomach pain	______	Bloating	______
Nausea	______	Vomiting	______
Constipation	______	Diarrhea	______
Urinary tract Infections	______	Frequent colds/flu's	______
Panic Attacks	______	Surgery	______
Broken Bones	______	Trauma/car accidents/falls	______

MENTAL/EMOTIONAL

Depression	______	Tantrums	______
Anxiety	______	Aggressive Behavior	______
Overly Fearful	______	Nervous	______
Phobias	______	Nightmares	______
Panic Attacks	______	Nervousness	______

Is your child particularly sensitive to any of the following below: (please circle below)

Cold heat darkness loud noises sunlight crowds heights

SLEEP

At what age did your child first sleep through the night? ______________________________

Does your child have difficulty falling asleep? ______________________________

How many hours of sleep per night? ______________________________

Does your child currently nap during the day? __________ For how long? ____________________

When was your child's last treatment with antibiotics? ____________________________________

Have you ever used any topical medicines on your child's skin? ____________________________

Has your child been vaccinated? ___________ Were the vaccines according to schedule? _______

FAMILY HISTORY:

Does your child have any siblings? (ages) ____

Any particular significant family health problems? ex.) diabetes, heart disease, high blood pressure, depression, cancer?

Childhood Illness: (please circle if your child has had any of the below illnesses)

Chicken pox   Measles   Ear Infections   Strep throat   Asthma

Eczema   Premature birth   Whooping cough   pneumonia   influenza

PRENATAL HISTORY

Were there any health concerns during the pregnancy? __________________________________

Was your child born premature? _______ if so, how early? _________________________________

Were there any difficulties or complications at birth? _____________________________________

Birth weight: _______________________ Birth length: __________________________________

Were there any concerns after birth or in the first year? (please circle below)

Infection   poor feeding   respiratory distress   skin conditions

Colic   anemia   jaundice   fever

Was your child breastfed? _____________ For how long? __________________________________

At what age were solid foods introduced? ____

Is there anything that your child does not currently eat in her/his diet? _____________________

Does your child attend daycare? ____

Anything else you would like to mention about your child's health:

____

____

____

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