

INTAKE FORM FOR CHILDREN

Child's Name: _____ Age: _____ D.O.B.: _____

Address: _____

Parent/Guardian's Name: _____

Address, if different from above: _____

What are your major concerns about your child's health?

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

Child's general state of health is: __ Excellent __ Good __ Fair __ Poor

Date of last physical: _____

Date of last dental exam if applicable: _____

Current Medications (including supplements, vitamins, and herbs):

Allergies (drugs, food, chemicals, etc):

Past operations / serious illnesses:

PRENATAL HISTORY:

Mother's age at child's birth: _____ Prenatal care? Y N
Difficulty conceiving? _____ Infertility treatments used? _____

During pregnancy, did the mother experience?

 Bleeding Drug/Alcohol Abuse Hypertension Medications
 Physical Trauma Thyroid Problems Gestational Diabetes

Specific food cravings/dislikes during pregnancy:

Did the Mother use any of the following during the pregnancy? (Please give details)

Tobacco _____

.

Alcohol _____

.

Recreational drugs _____

.

Prescription drugs _____

.

Over-the-counter medication _____

.

Supplements _____

.

Other _____

BIRTH HISTORY:

Pregnancy length: Full Premature _____ wks Late _____ wks

Length of labor: _____

Birth weight: _____ Length: _____

Was the birth: Vaginal C-section Induced Forceps

Any problems? _____

Did the child experience any of the following symptoms after birth?

 Jaundice Rashes Seizures Other

FEEDING/DIET HISTORY:

Breast Fed? _____ How long? _____

Formula Fed? _____ How long? _____ What type? _____

What foods were introduced before 6 months (please list approximate months as well):

6-12 months?

Did your child ever experience colic? _____ How severe? mild moderate severe
Please list any food allergies or intolerances, along with the reaction they provoke.

What foods does your child crave/insist upon?

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

Describe Child's Typical Daily Diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Number of bottles given per day: _____ Number of ounces per bottle: _____

CHILD'S MEDICAL HISTORY:

- | | | | | |
|---------------------------------------|--|---|--|--|
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Rubella | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Strep throat | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Colic | <input type="checkbox"/> Croup | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Roseola |
| <input type="checkbox"/> Impetigo | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Whooping Cough | | |

Immunization History: number received / number suggested

_ Diphtheria: /4 _ Pertussis: /4 _ Tetanus: /4 _ Polio: /4
_ Hepatitis B: /3 _ Measles: /2 _ Mumps: /2 _ Rubella: /2
_ H. Flu: /3 _ Tetanus booster? _____ _ Other?

Please indicate any adverse reactions to vaccines

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

When and for what reason? _____

HEALTH AND DEVELOPMENT:

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

If poor or fair circled, please describe: _____

At what age did your child, first

Sit up _____ Crawl _____ Walk _____ Talk _____

Describe your child's sleep pattern:

How would you describe your child's temperament?

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

ENVIRONMENT:

Is your child in: school (grade _____), daycare/homecare, or other _____

What are your child's favorite activities?

Does your child exercise regularly? Y N

How much, how often? _____

How much television does your child watch? _____ hrs a day/ week

How often does your child read (not for school)/How often does someone read to your child?
Daily Several times a week Weekly Less than weekly

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

Are there animals in the home? Y N

Type: _____

How is your child's home heated? _____

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

FAMILY MEDICAL HISTORY: Please note the diseases each family member has or had, their age at death, and cause of death if known:

Father: _____

Mother: _____

Paternal Grandfather: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

Maternal Grandmother: _____

Siblings: _____

DECLARATION AND CONSENT TO TREATMENT OF A CHILD

Child's name: _____ Date: _____

I, _____, hereby give my consent for Dr. Elizabeth Korza, ND and Dr. Cecilia Hart, ND, to treat my child or ward. I take responsibility for all fees incurred.

Signature: _____ Date: _____

Relationship to child: _____

Witness's signature: _____ Date: _____