



Child Intake Form

CHILD'S NAME: _____

D.O.B.: _____ AGE: _____ SEX: Male Female

Date: _____ Referred by: _____

Who is filling out this form (name and relation)? _____

CONTACTS: (in order of preference)

NAME: _____ PHONE: _____

Address _____ WORK: _____

_____ OTHER: _____

_____ EMAIL: _____

Relationship to child _____

Whom does the child live with? _____

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

1. _____

2. _____

3. _____

4. _____

5. _____

Other health care providers:

1.	2.	3.
_____	_____	_____
_____	_____	_____
_____	_____	_____
P:	P:	P:
(_____) _____	(_____) _____	(_____) _____

MEDICAL HISTORY

How would you describe your child's general state of health? **Excellent** **Good** **Fair** **Poor**

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 impetigo |
| n m a s measles | n m a s scarlet fever | n m a s mononucleosis |
| n m a s chicken pox | n m a s whooping cough | n m a s ear infections |
| n m a s mumps | n m a s strepthroat | |

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

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

Please list past prescription medications;

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

Please indicate what immunizations your child has had;

- DPT (diphtheria, pertussis tetanus) Haemophilus influenza B Hepatitis B
 Polio "Flu" Hepatitis A
 MMR (measles, mumps, rubella)
 Tetanus Booster When? _____

Other _____

Please indicate if any caused adverse reactions

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

PRENATAL HEALTH

1. What was the health of the parents at conception?

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

2. What was the health of the mother during the pregnancy?

- Poor Fair Good Excellent Unknown

3. What was the mother's age at child's birth? _____

4. How was the mother's diet during pregnancy?

- Poor Fair Good Excellent Unknown

5. Did the mother receive prenatal medical care? Y N Unknown

6. 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 the 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 Anaesthesia 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 fed and how long? _____ Formula Milk/Soy/Other: _____

Other: _____

What foods were introduced before 6 months? (Please list approximate month as well.)

6–12 months?

Did your child ever experience colic? Y N How severe? 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 _____

Describe your child's sleep pattern

How would you describe your child's temperament? _____

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

FAMILY HISTORY

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

- Allergies: _____ Asthma: _____ Diabetes: _____
 Birth Defects: _____ Kidney Disease: _____ Juvenile Arthritis: _____
 Other: _____ I don't know the family medical history

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

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ENVIRONMENT

Is the child in school, daycare, home care, or other? _____

What are your child's favorite activities? _____

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

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

How often does your child read (not for school), or 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

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? _____

THANK YOU FOR TAKING THE TIME TO FILL THIS FORM OUT

IF you are interested in a tailor-made Bach Flower Remedy for your child please fill out the Bach Flower Questionnaire as well. Bach Flowers are totally safe with zero side effects and work on healing emotional and behaviour issues.