DAWDY NATUROPATHIC CLINIC
RESTORE REPLENISH REJUVENATE
www.dawdynaturopathicclinic.com

CHILD INTAKE FORM

Dr. Kimberly Dawdy, B.A. (HONS), N.D.
6899 Sunset Blvd. Ottawa, ON, K4P 1C5
kim@dawdynaturopathicclinic.com
613-574-0069

PLEASE PRINT CLEARLY IN BLUE OR BLACK PEN

Child's name: _____

Gender:_____ Date of birth: _____ Age: _____

Parent's Name, Age and Occupation:

1. _____

2. _____

Parents are (circle one):

Married Separated Divorced Common law Other: _____

Parent contact information:

_____ _____ _____

Address City / Province Postal code

_____ _____

Phone number – Day Phone number – Evening

Email address: _____

Other health care providers your child is seeing (family doctor, specialist, chiropractor, etc…):

1. _____ 2. _____ 3. _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

( ) _____ ( ) _____ ( ) _____

May I contact the above to discuss your child's health/treatment? Yes No

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Chief concern	**How long has it been going on?**	**Had this been previously diagnosed/treated? How?**
1.		
2.		
3.		

Any known allergies to foods, medication, supplements, animals or environment?

_____
_____
_____
_____

List any surgeries or major illnesses (with dates):

_____
_____
_____
_____

List any current medications and/or supplements (please bring with you to first appointment):

_____
_____
_____
_____

List any past medications and/or supplements (include dates):

_____
_____
_____
_____

If your child has taken antibiotics, how many times? _____

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FAMILY MEDICAL HISTORY

	Age/Age at death	General health (excellent, good, poor)	Health conditions
Mother/father			
Mother/father			
Sibling 1			
Sibling 2			
Maternal grandfather			
Maternal grandmother			
Paternal grandfather			
Paternal grandmother			
Other			

Note: Parents of same sex families, please indicate the name of each parent listed.

Was your child adopted? Yes No

If yes, at what age:_____

HEALTH HISTORY

Please check all that apply (circle c=current or p=past):

Cradle cap	c	p	Eczema	c	p
Diarrhea	c	p	Constipation	c	p
Asthma	c	p	Anemia	c	p
Chronic sniffles/stuffiness	c	p	Diaper rash	c	p
Nightmares	c	p	Bedwetting	c	p
Allergies	c	p	Fears/phobias	c	p
Colds	c	p	Ear infection	c	p

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Lice	c	p	Conjunctivitis (pink eye)	c	p
Poor teeth	c	p	High fever	c	p
Hyperactivity	c	p	Extreme shyness	c	p
Chicken pox	c	p	Measles	c	p
Fifths disease	c	p	Erythema Infectiosum	c	p
Warts	c	p	Strep throat	c	p
Colic	c	p	Impetigo	c	p
Finicky eater/poor appetite	c	p	Hearing/vision problems	c	p
Thrush	c	p	Early puberty (before 11)	c	p
Tantrums	c	p	Mumps	c	p
Stomach aches	c	p	Other:		

Notes:

_____

_____

_____

_____

_____

_____

VACCINATION HISTORY

Check all vaccinations that have been administered (or attach copy of vaccination card)	Date received	Reactions (i.e. fever, seizure, mood change, infections, etc.)
MMR		
DTaP-IPV (Diptheria, Tetanus, Pertussis, Polio)		
Haemophilus influenza type B		
Pneumococcal		
Meningitis		
Varicella (chicken pox)		
Influenza (flu shot)		
Hepatitis A		
Hepatitis B		
Small pox		
HPV (Gardisil)		
Other		
Check here if you have chosen not to vaccinate your child		

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PRENATAL HISTORY

Were there difficulties conceiving? Yes No

# of pregnancies carried to term _____ # of pregnancies not carried to term _____

Mother's age at conception _____ Father's age at conception _____

Parent's health at conception (E= excellent G=good, P= poor) Mother: _____ Father: _____

Were any fertility interventions used? Yes No

If yes, explain:

_____
_____
_____
_____

Mother's pregnancy weight gain: _____lbs/kg

Were any of the following complications during pregnancy?

- ◯ Bleeding
- ◯ Swelling
- ◯ Herpes
- ◯ Gestational diabetes
- ◯ Nausea/vomiting
- ◯ Infections (ie. yeast)
- ◯ High blood pressure
- ◯ Accidents/Injuries
- ◯ Thyroid problem
- ◯ Excessive weight gain
- ◯ Excessive emotional stress
- ◯ Other:

Was the mother exposed to any of the following during pregnancy?

- ◯ Recreational drugs
- ◯ Second hand smoke
- ◯ Other:
- ◯ Alcohol
- ◯ Environmental toxins
- ◯ Cigarette smoke
- ◯ Caffeine: How much?

_____

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List any medications taken during pregnancy:

List any vitamins or other supplements taken during pregnancy:

Did mother travel during pregnancy? Yes No

If yes, describe:

_____

_____

Did mother work during pregnancy? Yes No

If yes, describe, until when?

_____

_____

What was mother's emotional state during the pregnancy? Describe significant relationships.

_____

_____

_____

_____

What is your overall impression of the pregnancy?

_____

_____

_____

_____

BIRTH HISTORY

Pregnancy length: _____ weeks

Length of labour: _____ hours/days

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Were any of the following used during the birth?

- ◯ Induced labour
- ◯ Epidural/anesthesia
- ◯ Pain medication
- ◯ Forceps
- ◯ Episiotomy
- ◯ C-section
- ◯ Vacuum extraction
- ◯ Oxytocin/Pitocin
- ◯ Other:

Birth weight:_____ Length: _____ Head circumference: _____

EARLY CHILDHOOD HISTORY

Did your child experience any of the following shortly after birth?

- ◯ Colic
- ◯ Rashes
- ◯ Difficulties feeding
- ◯ Jaundice
- ◯ Respiratory distress
- ◯ Anemia
- ◯ Infection/fever
- ◯ Birth defects
- ◯ Trauma
- ◯ Birth trauma/injuries
- ◯ Seizures
- ◯ Other:

At what age did the following occur?

Smiling _____ Crawling _____ Talking _____

Sitting _____ Walking _____

PERSONALITY

Describe your child:

_____
_____
_____
_____

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Does your child have any unusual habits?

_____
_____
_____
_____

Does your child have any fears?

_____
_____
_____
_____

How is your child's behaviour at home?

_____
_____
_____
_____

How does your child respond to discipline?

_____
_____
_____
_____

Is your child in: ◯ school ◯ daycare ◯ homecare ◯ other

What grade level? _____

General school/daycare behaviour and performance:

_____
_____
_____
_____

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Has your child been diagnosed with any learning disabilities?

_____
_____
_____
_____

What are your child's interests and favourite activities?

_____
_____
_____
_____

NUTRITION

Was the child breast-fed? Yes No If "yes", until what age?_____

Was formula introduced? Yes No If "yes", when: _____

What type of formula?_____

At what age were solid foods introduced? _____

In what order were foods were introduced? _____

Were there any noticeable reactions to foods introduced (rashes, changes in sleeping habits):

_____
_____
_____
_____

Describe any current dietary restrictions (food intolerances/ allergies, religious, vegetarian, vegan, etc.):

_____
_____
_____
_____

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What are your child's favourite foods?

_____
_____
_____
_____

Least favourite foods?

_____
_____
_____
_____

Describe the child's present eating habits:

_____
_____
_____
_____

List your child's dietary intake for the last 24 hours:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

What is the source of your household's drinking water?

Well Tap Filtered Distilled Bottled spring Reverse osmosis

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ENVIRONMENT

Whom does your child live with? _____

Describe the emotional climate of your child's home?

_____
_____
_____
_____

Is your child sensitive to any of the following?

◯ Cold	◯ Height	◯ Touch
◯ Heat	◯ Sunlight	◯ Noise
◯ Wind	◯ Music	◯ Emotions
◯ Draft	◯ Wool	◯ Other:
◯ Smell	◯ Small spaces	

How many hours per day/week does your child:

Play on the computer or video games _____

Watch TV _____

Read (not for school) _____

Exercise _____

SLEEP

How many hours does your child sleep at night? _____ Naps? _____

Describe bedtime:

_____
_____

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Does your child wake during the night? Yes No If yes, how often? _____

Does your child have nightmares? Yes No If yes, how often? _____

Does your child wet the bed? Yes No If yes, how often? _____

Is this a change? _____

Does your child snore? Yes No

What position does your child sleep in? _____

Is there anything else about your child that you would like me to know?

_____
_____
_____
_____
_____
_____
_____
_____