Dr. Laura Pipher, ND
Child Intake Form (4-15 years)

Date: _____

Name of Person Completing intake forms: _____

Relationship to Child _____

Personal Information

Full name of child: _____

Date of birth _____ Age: _____ Sex: _____

Home address (Street, City, Province, Postal Code):

_____

With whom does the child live: _____

Does the child have siblings? Y/ N

If yes, how many? _____

Telephone (Primary): _____ (Mobile/home/work)

Email address (of parent or guardian): _____

Emergency contacts:

Name: _____ Phone number: _____ Relation to child: _____

Name: _____ Phone number: _____ Relation to child: _____

Healthcare Team

Family Physician: _____ Phone: _____

Other healthcare providers:

Name/ Profession: _____ Phone: _____

Name/ Profession: _____ Phone: _____

Name/ Profession: _____ Phone: _____

How did you hear out about me?

Please List **ALL Current Health Concerns** (in order of importance)

1.	2.
3.	4.
5.	6

Please List Any **Allergies** (food, drug, environmental etc) **& note their severity**:

Immunizations

Please indicate which of the following immunizations your child has received:

- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ RV (rotavirus)
- ☐ DTaP* (diphtheria, tetanus, pertussis)
- ☐ PCV (pneuomococcal)
- ☐ IPV (Polio)
- ☐ Hib (Haemophilus influenza type b)
- ☐ Influenza (Flu vaccine)
- ☐ Chicken pox (varicella)
- ☐ MMR (measles, mumps, rubella)
- ☐ Tetanus Booster – When? _____
- ☐ HPV (Gardasil)
- ☐ Meningococcal conjugate
- ☐ Pneumococcal Conjugate

Has your child ever experienced any adverse reactions to any vaccinations? Y / N

If YES, explain: _____

Prenatal health

What was the age of the **mothe**r at child's birth? _____ **father?** _____

Was this the mother's first pregnancy? Y / N

Did the mother experience any of the following during pregnancy?

- ☐ High blood pressure
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Bleeding
- ☐ Nausea & vomiting
- ☐ Physical or emotional trauma

Did the mother use any of the following during pregnancy?

- ☐ Alcohol
- ☐ Tobacco- If no, was there any second hand exposure? _____

- ☐ Recreational drugs : _____

- ☐ Over the counter drugs: _____

- ☐ Supplements: _____

Did the mother receive prenatal care during pregnancy? _____

Birth history

Please check **Any of the following** that apply to the child's birth:

- ☐ Induced
- ☐ Vaginal birth
- ☐ C section
- ☐ Forceps used
- ☐ Anesthesia (epidural) used

Were there any complications during birth? Y / N

If YES, Explain:

_____

Diet

Was your child breastfed? Y / N For How long? _____

Any food intolerances (other than those allergies listed above) ? Y / N

If YES, Explain:

_____

Any dietary restrictions? Y / N

If YES, explain:

_____

Describe a typical day's diet:

Breakfast: _____

Lunch _____

Dinner: _____

Snacks: _____

Beverages: _____

Medical History

Please list **ALL Over the counter products** the child is currently taking (including supplements, herbs, vitamins, homeopathics and non prescription medication)

Product	**Dosage and frequency**

Please list **ALL Prescription Medication** the child is currently taking

Product	**Dosage and frequency**

Past medical history

Has your child ever had **any serious conditions, illnesses, injuries or diseases** in the past? Please include approximate dates:

_____

_____

_____

_____

Family Health History

Please check the **YES** box beside any conditions affecting family members, and indicate who (F- father, M-mother, G-Grandparent, S- sibling). Please circle whether the condition is **Past or Current**

Condition	**YES**		**Relation**	**Condition**	**YES**		**Relation**
Asthma		Past Current	M F G S	High blood pressure		Past Current	M F G S
Allergies		Past Current	M F G S	Heart disease		Past Current	M F G S
Anemia		Past Current	M F G S	Hepatitis		Past Current	M F G S
Arthritis		Past Current	M F G S	Headaches		Past Current	M F G S
Cancer		Past Current	M F G S	Kidney Disease		Past Current	M F G S
Diabetes		Past Current	M F G S	Stroke		Past Current	M F G S
Eczema		Past Current	M F G S	Tuberculosis		Past Current	M F G S
Epilepsy		Past Current	M F G S	Osteoporosis		Past Current	M F G S
Mental illness		Past Current	M F G S	Autoimmune disease		Past Current	M F G S
Addiction		Past Current	M F G S	Other:		Past Current	M F G S

Environment

How many **hours per week** does your child spend:

Watching TV _____ On the computer/ playing video games _____

What types of activities does your child enjoy? _____

Describe the **emotional climate** of the home:

_____

Are there any pets in the house? Y / N

Is there anything else?

_____

_____

_____