Sandra Koch B.Sc., ND: Child Intake

Child's Name: _____ Age: ____ Gender: Male/Female

Date of birth: _____ (day/month/year)

Address: _____
Street City Postal Code

Home Phone: ( ) _____

Parent(s) or Guardian(s): _____ Relationship to patient: _____

Address: _____
Street City Postal Code

Home Phone: ( ) _____ Work Phone: ( ) _____

Occupation: _____ Employer: _____

May we leave messages relating to your child's visit at your: Home: Yes / No Work: Yes / No

Person to contact in case of emergency: _____ Relationship: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Other Health Care Providers:

1. _____
_____
_____
( ) _____

2. _____
_____
_____
( ) _____

3. _____
_____
_____
( ) _____

What are your child's main health concerns in order of importance? In your opinion, what do you believe caused these conditions?

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

Reason for visit if different from above: _____
_____
_____

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

Please email the completed form to nd_sandra@yahoo.com or fax to (905) 309-0590.
Address: 55 Livingston Ave, Grimsby ON

Past Medical History

Please circle: Chicken pox, Mumps, Tonsillitis, Rheumatic Fever, Frequent Colds, Pneumonia, Measles, Seizures, Sexual Abuse, Scarlet Fever, Rubella, Whooping cough, Ear Infections

Emotional trauma: _____

Physical Trauma: _____

Any allergies: _____

Operations/Hospitalizations: _____

List Past or Present:

Medications: _____

Antibiotic use: Yes / No How often? _____

Supplements: _____

Family Health History

Please fill in/list the affected family members(s):

Heart disease _____ Birth defects _____ Kidney disease _____

AIDS _____ Mental Illness _____ Alcoholism _____

Asthma _____ Cancer _____ Diabetes _____

Arthritis _____ Eczema _____ Psoriasis _____

Allergies _____ Hypertension _____ Tuberculosis _____

Multiple Sclerosis _____ Drug Abuse _____

Prenatal History:

Father's health before conception: _____

Mother's health before conception: _____

Mother's Health During Pregnancy (please circle)

Bleeding/spotting, Thyroid problems, Hypertension, Medications, Diabetes, Nausea/Vomiting, Illnesses, Toxemia, Cigarette/Alcohol/Drug Consumption, Physical/Emotional trauma,

Other: _____

Please email the completed form to nd_sandra@yahoo.com or fax to (905) 309-0590.
Address: 55 Livingston Ave, Grimsby ON

Mother's age at child's birth: ____

Any history of abortions _____, miscarriages _____, infertility _____

Was this a planned pregnancy? _____

Birth History

Where did birth take place? _____

Spontaneous or Induced? _____

Length of term (please circle one) : Full / Premature / Late

Type of delivery (please circle one): Vaginal / C-Section

APGAR Score: _____

Length of Labour: _____ Complications? _____

Interventions (please circle): Epidurals, Episiotomy, Suction, Forceps, Pitosin drip

Medications during or after birth: _____

Birth weight: _____ Height: _____

Complications at Birth or soon after (please circle):

Anemia, Jaundice, Cyanosis, Colic, Seizures, Respiratory distress, Thrush, Fever, Rashes, problems feeding

Infections: _____

Birth Injury: _____

Immunizations (please circle):

Measles, Mumps, Rubella, Diphtheria, Pertussis, Tetanus, Polio, Influenza, Small Pox, Hepatitis,

Chicken Pox, Others: _____

Any adverse Reactions? _____

Child's Diet/Lifestyle

Breast-fed: Yes / No How long? _____ Any problems: _____

Formula used: _____ How long _____ Any problems: _____

First foods introduced: _____ What age ___

Any problems: _____

Did you notice any allergies or food intolerances? _____

Please email the completed form to nd_sandra@yahoo.com or fax to (905) 309-0590.
Address: 55 Livingston Ave, Grimsby ON

Age child began: Sitting _____ Crawling _____ Walking _____ First Word _____

Hours Sleep/Night (currently): _____

Trouble falling asleep: Yes / No Wakes easily: Yes / No

How many different homes have you lived in? _____

How has this affected your child? _____

Age started school/daycare? _____ Effect on child/experience of child: _____

_____

Age child was toilet trained: _____ Any bed-wetting? _____ Age? ____

Child's Environment:

How many siblings: ___ Brothers: ____ age(s): _____ Sisters: ____ age(s): _____

Any pets? _____ What kind? _____

Amount and type of exercise/sports: _____

Recent renovations in the home? _____

Smoking by anyone at home?_____

Any chemical exposure(s)?_____

Siblings / Family / Environment / Daycare / School / Pets (Please elaborate and add anything you feel may affect child's well being) _____

_____

General Symptoms (please circle if current symptom and underline if past symptom):

Cough	Nightmares	Frequent colds	Allergies	Sore Throat
Anemia	Nervousness	Stomach aches	Night sweats	Eczema
Diarrhea	Unusual fears	Sleep problems	Nosebleeds	Cries easily
Wheezing	Dizzy spells	Frequent headaches	Hair loss	Burning urine
No appetite	High fever	Excessive fatigue	Bed-wetting	Visual problems
Easy bruising	Canker sores	Body/Breath odour	Joint Pain	Chronic rash
Gas	Jaundice	Light sensitivity	Cradle Cap	Motion/Car sickness
Acne	Constipation	Frequent vomiting	Hearing loss	Mood problems
Night terrors	Heart murur			

Anything not yet covered: _____

Please email the completed form to nd_sandra@yahoo.com or fax to (905) 309-0590.
Address: 55 Livingston Ave, Grimsby ON