

Dr. Kristen Brown, ND
202-6411 Nelson Avenue, Burnaby, BC
604-430-1525

Children's Intake Form – please fill in for children up to 12 years of age

Please complete the following form as thoroughly as possible. All information is confidential.

Name: _____ Today's Date: _____
Address: _____ City: _____
Province: _____ Postal Code: _____
Phone: (h) _____ Phone: (cell) _____
E-mail: _____ Date of Birth: _____
Care Card / Personal Health Number: _____
Parent's / Guardian's names: _____
Emergency Contact Person: _____ Phone: _____
Family Doctor's or medical clinic address/phone:

Date of last visit to Doctor/Clinic: _____

Has your child had the routine check-ups as recommended by their health care provider?

Is your child under the care of a medical specialist? Y _____ N _____

Name/specialty: _____

Health Concerns – Please list:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Does your child have any life threatening allergies? Y _____ (list below) N _____

Please list any over the counter or prescribed medications and/or vitamins/supplements:
(include dosage)

How did you hear about our clinic? _____

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Past Medical History

Please check if your child has concerns with any of the below:

SKIN

Hives	_____	Itching	_____
Rash	_____	Excessive dryness	_____
Cradle Cap	_____	Swollen Glands	_____
Excessive sweating	_____		

ALLERGIES

Seasonal Allergies	_____	Hay fever	_____
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MOUTH/GUMS

Sore throat	_____	Gum problems	_____
Teething pain	_____	Canker sores	_____
Cold sores	_____	Cracked lips	_____
Removal of Tonsils	_____	Thumb sucking	_____

GENERAL

Fainting	_____	Seizures	_____
Vision problems	_____	Pink Eye (conjunctivitis)	_____
Shortness of breath	_____	Wheezing	_____
Cough	_____	Stutter/Lisp speech	_____
Excessive appetite	_____	Picky eater	_____
Spitting up frequently	_____	Acid Reflux	_____
Stomach pain	_____	Bloating	_____
Nausea	_____	Vomiting	_____
Constipation	_____	Diarrhea	_____
Urinary tract Infections	_____	Frequent colds/flu's	_____
Panic Attacks	_____	Surgery	_____
Broken Bones	_____	Trauma/car accidents/falls	_____

MENTAL/EMOTIONAL

Depression	_____	Tantrums	_____
Anxiety	_____	Aggressive Behavior	_____
Overly Fearful	_____	Nervous	_____
Phobias	_____	Nightmares	_____
Panic Attacks	_____	Nervousness	_____

Is your child particularly sensitive to any of the following below: (please circle below)

Cold heat darkness loud noises sunlight crowds heights

SLEEP

At what age did your child first sleep through the night? _____

Does your child have difficulty falling asleep? _____

How many hours of sleep per night? _____

Does your child currently nap during the day? _____ For how long? _____

When was your child's last treatment with antibiotics? _____

Have you ever used any topical medicines on your child's skin? _____

Has your child been vaccinated? _____ Were the vaccines according to schedule? _____

FAMILY HISTORY:

Does your child have any siblings? (ages) _____

Any particular significant family health problems? ex.) diabetes, heart disease, high blood pressure, depression, cancer?

Childhood Illness: (please circle if your child has had any of the below illnesses)

Chicken pox Measles Ear Infections Strep throat Asthma

Eczema Premature birth Whooping cough pneumonia influenza

PRENATAL HISTORY

Were there any health concerns during the pregnancy? _____

Was your child born premature? _____ if so, how early? _____

Were there any difficulties or complications at birth? _____

Birth weight: _____ Birth length: _____

Were there any concerns after birth or in the first year? (please circle below)

Infection poor feeding respiratory distress skin conditions

Colic anemia jaundice fever

Was your child breastfed? _____ For how long? _____

At what age were solid foods introduced? _____

Is there anything that your child does not currently eat in her/his diet? _____

Does your child attend daycare? _____

Anything else you would like to mention about your child's health:
