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Homecoming
Naturopathic Medicine

CHILD NEW PATIENT INTAKE FORM

Date: mm / dd / yyyy

Name:_______________________________________ Date of birth: mm / dd / yyyy

Gender: ____________________

Parent names:

____

Address:____

Phone numbers
Home____________________ Cell ________________________

Parents' occupations
Current: ____

Occupations in the past: ____

Emergency contact
Name: ____________________ Phone number: ____________________ Relation: ____________________

Family doctor/pediatrician
Name: ____________________ Address: ____

Phone number: ____________________

Other health care providers
Name: ____________________ Specialty: ____________________ Phone number: ____________________

How did you hear about the ND? ____________________

Please describe your child's primary health concerns

____

____

____

____

Which therapies have been tried? Have they helped?

____

____

____

Please list any other health concerns your child may have

____

____

Personal medical history

Please list any medical conditions, serious illnesses, injuries, and diagnoses your child has received now or in the past, dates, and how they were diagnosed

____

____

____

____

Has your child:

Been sick often? ☐No ☐Yes ____

Ever been hospitalized? ☐No ☐Yes ____

Received any surgeries? ☐No ☐Yes ____

Taken or now takes antibiotics? ☐No ☐Yes How many times? ______________________

Taken or now takes any other medications (including over the counter)? ☐No ☐Yes ________

____

Taken or now takes any supplements/vitamins? ☐No ☐Yes ___________________________

____

Any allergies (food, environmental, medical)? ☐No ☐Yes ___________________________

____

Even had (please check all that apply, and indicate age, and the number of times):

☐Rubella	☐Measles	☐Chicken pox	☐Mumps
☐Roseola	☐Scarlet fever	☐Whooping cough	☐Strep throat
☐Impetigo	☐Mononucleosis	☐Ear infections	☐Fifth's disease

Please check which vaccinations your child received, and indicate at which age:

☐DPT	☐MMR	☐Haemophilus influenza B	☐Influenza (flu)
☐Hepatitis B	☐Tetanus	☐Chicken pox	☐HPV
☐Rotavirus	☐RSV	☐Meningitis	☐Polio

Have there ever been adverse reactions to vaccines? ☐No ☐Yes ______________________

____

Has you child ever received specialized screening tests: ☐No ☐Yes ____________________

____

Prenatal and Birth history

Health of the mother before conception: ☐Good ☐Fair ☐Poor ☐Unknown

Health of the mother during pregnancy: ☐Good ☐Fair ☐Poor ☐Unknown

Has the mother experienced any of the following during pregnancy:
☐ Bleeding ☐Diabetes ☐High blood pressure ☐Vomiting ☐Thyroid issues
☐ Physical trauma ☐Emotional trauma ☐Cigarette smoking ☐Drug use ☐Alcohol use

Was there prenatal care provided by a healthcare provider? ☐No ☐Yes ☐Unknown

Child's birth:
☐Induced? ☐Vaginal? ☐C-section? Number of weeks:_________ Length of labor:_____________
Were there any difficulties or complications? ☐No ☐Yes ____
____
Were antibiotics used during labor? ☐No ☐Yes
Child's weight and height at birth: ____

Nutrition

Child's feeding: ☐Breastfed ☐Formula fed ☐Both
Please describe solid food introductions, including type of food and age of introduction:

____
____
____

Have any food sensitivities? ______________________________________

Does your child have dietary restrictions (eg. vegetarian, vegan, religious, etc)? ☐No

☐Yes______________________________________

Please describe your child's diet on a typical day:

Breakfast:____

Lunch: ____

Dinner: ____

Snack: ____

Beverages (including water): ____

Development and lifestyle

Age when you child began:

Sitting _______________ Crawling_______________ Walking_______________ Talking_______________

How would you describe your child's overall development?
Physically: ☐Average ☐Slow ☐Fast Mentally: ☐Average ☐Slow ☐Fast

Has your child started puberty? ☐No ☐Yes. At what age? __________

Please describe your child's sleep patterns and any difficulties with sleep:

____
____

Please describe your child's temperament:

____

____

____

Is your child: ☐At home? ☐At school? ☐At daycare? ☐Other:_______________________
Please describe your child's behavior and performance at day care/school, and their attitude towards it:

____

____

____

Please describe your child's interests and extra-curricular activities:

____

____

How much screen time does your child get? What type of exercise do they get per day?

____

____

Who does the child live with? ____

Does anyone in the household smoke? ☐No ☐Yes
Are there pets at home? ☐No ☐Yes ____________________
Is the child exposed to any noxious chemicals, toxins, or other hazards? ☐No
☐Yes____
Please describe the emotional climate of your household and its stress levels:

____

____

____

Family history

Please indicate which conditions are present in your family, and which family member has the conditions in relation to your child (eg. father, sister, maternal grandmother, etc)
☐ Check here if you do not know your family history

	Alcoholism/addiction		Heart disease
	Allergies		High blood pressure
	Anemia		High cholesterol
	Arthritis		Kidney disease
	Asthma		Liver disease
	Cancer		Osteoporosis
	Diabetes		Stroke
	Eczema/psoriasis		Tuberculosis
	Epilepsy		Depression/other mental illness
	Headaches/migraines		

Any other conditions that have not been listed? ______________________________

Review of body system

*Please place a check mark ✓ beside any issues your child currently experience, or a **P** beside issues that your child had in the past*

General
☐Unintentional weight loss
☐Unexplained weight gain
☐Fatigue
☐Weakness
☐Poor sleep/insomnia/nightmares
☐Sweating and/or night sweats

Emotional
☐Depression/cries easily and often
☐Anxiety/nervousness
☐Mood swings/irritability
☐Fears/phobias
☐Substance abuse
☐Eating disorder
☐History of abuse

Skin and hair
☐Rashes/hives
☐Acne
☐Discoloration
☐Dryness
☐Eczema
☐Psoriasis
☐Itching
☐Temperature changes
☐Moles

Head
☐Headaches
☐Head injury
☐Dizziness

Ears
☐Impaired hearing
☐Earache
☐Discharge
☐Frequent ear infections

Nose and sinus
☐Impaired sense of smell
☐Frequent colds/ sinus infections
☐Congestion
☐Itching
☐Discharge
☐Nose bleeds
☐Post-nasal drip
☐Polyps or deviated septum

Eyes
☐Impaired vision
☐Glasses/contacts
☐Eye pain
☐Redness
☐Itchiness
☐Discharge
☐Dry eyes
☐Blurring/double vision
☐Glaucoma
☐Cataracts

Mouth and throat
☐Frequent sore throat
☐Tonsilitis or laryngitis
☐Hoarseness
☐Canker sores
☐Cold sores
☐Loss of taste
☐Dental/gum issues
☐Jaw pain
☐Goiter
☐Swollen glands

Respiratory
☐Asthma/wheezing
☐Sleep apnea
☐Cough
☐Phlegm
☐Bronchitis
☐Pneumonia
☐Shortness of breath
☐Coughing up blood
☐Tuberculosis

Cardiovascular
☐Chest pain
☐Palpitations/fluttering
☐High blood pressure
☐Heart murmurs
☐Rheumatic fever

Gastrointestinal
☐Change in appetite
☐Change in thirst
☐Trouble swallowing
☐Heartburn
☐Indigestion
☐Abdominal pain
☐Nausea/vomiting
☐Belching
☐Ulcers
☐Excessive gas
☐Bloating
☐Constipation
☐Diarrhea
☐Changes in stool quality
☐Changes in stool frequency
☐Liver/gall bladder disease
☐Worms/parasites

Urinary
☐Pain on urination
☐Difficult urination
☐Frequent urination
☐Bedwetting
☐Frequent infections
☐Blood in the urine
☐Incontinence
☐Kidney stones
☐Kidney disease

Endocrine
☐Heat/cold intolerance
☐Thyroid problems
☐Changes in thirst/hunger
☐Diabetes
☐Blood sugar problems
☐Hormonal problems

Female reproductive
Age of first period _________
Length of cycle _____________
Length of period ___________
☐Irregular cycle
☐Very short or very long cycle
☐No periods
☐Bleeding between periods
☐Heave periods
☐Scanty periods
☐Painful periods
☐PMS
☐Breast tenderness
☐Ovarian cysts
☐Uterine fibroids
☐Vaginal discharge
☐Vaginal itching
☐Yeast infections

Breast	**Neurological**	**Male reproductive**
☐Lumps ☐Pain ☐Nipple discharge	☐Fainting ☐Seizures ☐Paralysis ☐Numbness ☐Tingling ☐Memory loss ☐Balance/gait problems ☐Difficulty with movement	☐Hernia ☐Testicular mass ☐Testicular pain ☐Discharge ☐Sores/rashes
Anything else you feel is important to share?	**Peripheral circulation** ☐Deep leg pain ☐Cold hands/feet ☐Varicose veins ☐Swollen hands/ankles/feet ☐Extremity numbness/coldness ☐Extremity ulcers ☐Anemia ☐Easy bruising	**Musculoskeletal** ☐Joint pain/swelling ☐Stiffness ☐Muscle weakness ☐Muscle pain ☐Muscle spasms/cramps ☐Back pain ☐Broken bones