Cure Integrative Clinic
www.cureclinic.ca
483 Dundas Street West, Unit 207
Oakville, ON, L6M 1L9
Phone: 905 581 5856

**Cure Integrative Clinic Forms**

**Child Intake Form**

1. **Patient Information**

Name:_____________________________________________ Referred by__________________________

(First) (Last) (Initial)

Date of Birth: year/month/day ___________________________________Age_____________

Gender:_______________________________________________________________________

Place of birth: _City___________________________Country___________________________

Address:_____________________________________________________________________________________

Street/ City/Province/Country

Postal Code: _________________________________

Phone:________________________________________________________________________________________

(Home) (Cell) (Work)

2. **Emergency contact information:**

Name:______________________________________________________________________

Phone:______________________________________________________________________

Address: ____________________________________________________________________

Relationship to patient:________________________________________________________

3. **Insurance Information**

Health insurance provider: ______________________________________________________

Policy Subscribers name: _______________________________________________________

Policy Subscriber's Date of Birth: ________________________________________________

Patient's relationship to subscriber: _____________________________________________

Health Insurance policy number __________________________________________________

4. **General Information:**

Family physician/referring physician:

_____________________________________________________________________________________

Name Phone

How did you know about our clinic? _______________________________________________________

When was your child’s last physical exam? ________________________________________________________

(Month) (Year)

Have you consulted a naturopathic doctor regarding your child health concerns before? Yes/No

Have you consulted a medical doctor regarding your child health concerns before? Yes/No

List your child health care providers (Specialist physician, Naturopathic doctor, Chiropractor, Registered massage therapist, Osteopath)

- ___________________________________________
- ___________________________________________
- ___________________________________________
- ___________________________________________
- ___________________________________________

5. **General Health Information:**

**Please list all your child's current health concerns:**

1. _________________________________
2. _________________________________
3. _________________________________
4. _________________________________

**Does your child have any of the following symptoms? Please check.**

| | | | |
|---|---|---|---|
| Fever | Chest pain | Insomnia | Dizziness |
| Headaches | Palpitation | Weight gain | Blurred vision |
| Constipation | Shortness of breath | Weight loss | Hearing loss |
| Diarrhea | Fatigue | Loss of appetite | Cough |
| Abdominal pain | Weakness | Runny nose | Wheezes |
| Heartburn | Rash | Sinus congestion | Anxiety |
| Blood in stool | Pain with urination | Sore throat | Depression |
| Blood in urine | Allergies | Ringing in the ear | Difficult focusing |

**Current Health status:**

On a scale of 1-10, 10 being the best, how would you rate the following for your child:

- Level of Energy: _______ Best in: Evening/Morning /Nights
- Level of Stress: ________
- Sleep quality: ________
- Mood: _______________
- General health status: _________

**Please list your health goals for your child :**

- _______________________________________________
- _______________________________________________
- _______________________________________________

**Please list all your child's medications:**

| **Medication** | **Started on** | **Reason** | **Prescribed by** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Please list all your child's supplements:**

| **Supplement** | **Dose** | **Brand** | **Started on** | **Recommended by** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**Have your child ever had any of the following diagnostic tests? Please check.**

| | |
|---|---|
| Electrocardiogram (EKG) | Endoscopy |
| X-ray | Ultrasound |
| CT scan | Any other diagnostic tests |
| MRI | |

**6. Past medical history:**

**Please list all previous surgeries, major illness, or hospital admissions:**

- _______________________________________________
- _______________________________________________
- _______________________________________________
- _______________________________________________

**Allergies:**

- Drug allergies: _______________________________________________
- Environmental allergies: _______________________________________________
- Food allergies: _______________________________________________

**Please check any of the following conditions your child has experienced in the past:**

| Allergies | Ear infections | Rubella | Asthma | Strep throat | Frequent colds | Measles | Mumps |
|---|---|---|---|---|---|---|---|
| Chicken Pox | Motion sickness | ADHD | Abdominal pain | Gas | Constipation | Diarrhea | Weight loss |
| Whooping cough | Parasites | Eczema | Pneumonia | Bleeding per nose | Headaches | Cradle cap | Croup |

**7. Social information:**

1. With whom does your child live? List names, age, relationship:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

2. Is your child frequently exposed to animals (pets, etc.)? Yes/No, Explain_________________________________

3. Where does your child live? ____Apartment _______House_______Other________________________

4. How old is your house:_______________________Have been there any renovations or new constructions?______________________Any flooding________________Any mold?________

5. Does your child live near high voltage electric towers ____? Do you live near a golf course_____? Do you live near a factory?_______Do you live near a farm? _________

6. Has your child traveled or lived outside Canada recently?_____ When? _______ Where?_______________For how long?___________

7. Has your child experienced any traumatic life event? ______________________________________

8- Has your child experienced a new major change in your life?______________________________

9- Any camping over the last 5 years?_____When? _____________ Where?_____________

10. How important is religion (or spirituality) for your family's life?

a. _____ not at all important
b. _____ somewhat important
c. _____ extremely important

11. Is your child exposed to secondhand smoke at home or at school?_Yes/ No, Explain_______________________

12. If your child moved to Canada with you, when was that? ___________Where did you move from? _______

13. Was your child born: Normal delivery/C section? 14. Has your child received antibiotics more that 5 times: Yes/No

15. When was the last time your child received any of the following medications?

- Antibiotics: __________________________
- Cortisone: __________________________
- Pain killers: __________________________

16. Does your child have any surgical implants (Cosmetic, medical, etc.)? _______________________________

17. Has your child had any dental work done? ______________________________________________________

**8. Vaccination History**

Is your child vaccinated following the schedule? Yes/No

Has your child had any adverse reactions to any of the vaccinations he received? Yes/No, If yes, please explain:

_______________________________________________________________________________

**9. Nutritional History:**

Was your child breastfed? Y/ N If so, for how long? ______________________________

Was your child formula fed? Y/N If so, which formula? _____________________________

At what age was solid food introduced? ____________ Any reactions? _______________________________

Which foods were introduced first? ______________________________________________________________

At what age was cow's milk introduced? ____________ Any reactions? ________________________________

Are there any foods that are excluded from the child's diet? If so, please explain:
_______________________________________________________________________________

How does your child eat? (good, picky eater, often, eats little, eats a lot, etc.)______________________________

How much does your child drink? _____________________ What do they drink? _________________________

How many servings of vegetables does your child eat per day? ___________________________________________

How many servings of fruits does your child eat per day? ______________________________________________

How many servings of red meat does your child eat per week? ___________________________________________

How many servings of chicken does your child eat per week? ___________________________________________

How many servings of fish does your child eat per week? ______________________________________________

**10. Family history:**

Please check the applied health condition for each relative?

| | Mother | Father | Grandparents | Sisters | Brothers |
|---|---|---|---|---|---|
| Age | | | | | |
| Heart disease | | | | | |
| Diabetes | | | | | |
| High blood pressure | | | | | |
| Asthma | | | | | |
| Cancer | | | | | |
| Stroke | | | | | |
| Heart attack | | | | | |
| Autoimmune condition | | | | | |
| Mental health condition | | | | | |
| Obesity | | | | | |
| Thyroid | | | | | |