ZAWADA HEALTH Child Intake Form

Welcome to Zawada Health, where the health of your family is our priority. Offering the services of Naturopathic Doctors, Registered Massage Therapists, a Chiropractor, a Psychotherapist, a Hypnotherapist, infrared sauna and a full product dispensary, we develop customized wellness plans for each member of your family. Our full range of professional services will change the way you think about your health, providing ample time for discussion and explanation of any treatments. Using traditional wisdom and modern research, we strive to provide you with safe and effective solutions that fit your lifestyle.

Child's Information

Name: _____
(Surname) (First) (Preferred name)

Sex: ☐ Male ☐ Female Age: _____ Height: _____ Weight: _____

Is your child currently (or has s/he previously been) under the care of an alternative healthcare provider (e.g. naturopathic doctor, acupuncturist, homeopath, chiropractor)? o No o Yes, specify _____

Please list your child's chief health concerns in order of importance.

_____
_____
_____

Please list all medications (prescription, over-the-counter) and natural products your child is currently taking.

Medication / Natural Product (please indicate brand where applicable)	Dose/quantity per day	Why are you taking this product?

Please list your child's past prescription medications (if any).

Medication	Dose/quantity per day	Why was this medication prescribed?

How many times has your child been treated with antibiotics? _____

Has your child ever experienced adverse effects or an allergic reaction to any of the above products?
☐ No ☐ Yes, specify _____

Please list any allergies or sensitivities (food, environment, medication) your child currently or has previously experienced.

_____
_____
_____

Please list any allergies or sensitivities (food, environment, medication) your child currently or has previously experienced.

_____
_____
_____

Please indicate any serious conditions, illnesses, injuries and/or hospitalizations your child has experienced.

Description	Year	Outcome/complications?

Please check off any condition(s) your child currently or has previously experienced.

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

Please indicate check off the immunizations your child has had.

☐ Chicken pox (varicella) ☐ Influenza (flu) ☐ Hep A
☐ MMR (measles/mumps/rubella) ☐ Meningitis ☐ Hep B
☐ Tetanus booster; when? _____ ☐ DTP (diphtheria) ☐ Polio
☐ HIB (haemophilus influenza B) ☐ Other, please specify: _____

Did your child experience any adverse effects following any of these immunizations?

_____

Prenatal Health

How was the health of the parents at conception? Please specify any relevant health conditions.

Mother : _____

Father : _____

How was the health of the mother during the pregnancy? Please specify any relevant health conditions.

_____
_____

What was the mother's age at the child's birth? _____

How was the mother's diet during pregnancy?

☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Unknown

Did the mother receive prenatal medical care? ☐ No ☐ Yes

Did the mother experience any of the following during the pregnancy?

☐ Bleeding ☐ High blood pressure ☐ Nausea ☐ Vomiting
☐ Diabetes ☐ Thyroid Problems ☐ Physical or emotional trauma
☐ Other, please specify: _____

Did the mother use any of the following substances during pregnancy?

☐ Tobacco ☐ Alcohol
☐ Recreational drugs: _____
☐ Prescription medications: _____
☐ Over-the-counter medications: _____
☐ Supplements: _____
☐ Other: _____

Birth History

Term length: ☐ Full ☐ Premature: _____ wks ☐ Late: _____ wks

Type of birth: ☐ Vaginal ☐ C-Section ☐ Induced ☐ Forceps ☐ Anesthesia used

Length of Labour: _____ Any complications? Please specify: _____

Did the child experience any of the following at or shortly after birth?

☐ Jaundice ☐ Rashes ☐ Seizures
☐ Birth injuries, please specify: _____
☐ Birth defects, please specify: _____
☐ Other, please specify: _____

Health & Development

At what age did your child first:
Sit up _____ Crawl _____ Walk _____ Talk _____ Show teeth _____

Describe your child's … sleep pattern: _____
… temperament: _____
… behaviour and performance at school: _____

Diet

How was your child first fed?
☐ Breast milk. How long? _____ ☐ Formula: Cow/Goat/Soy milk. _____ ☐ Other: _____

Food introduction

Age (months)	Food introduced (please specify approximate month)
Before 6 months	
6 to 12 months	

Did your child experience colic? ☐ No ☐ Yes Please specify severity: mild / moderate / severe

Does your child have any dietary restrictions (religious, vegetarian, vegan, etc.)? ☐ No ☐ Yes
Please specify: _____
_____

Typical daily diet

Breakfast	Lunch	Dinner	Snacks	Beverages (and total quantity)

Family History

Please check off any conditions currently or previously experienced by your child's close relatives (parent, sibling).

	Please specify the relative		Please specify the relative
o Allergies	_____	o Depression (mental illness)	_____
o Asthma	_____	o Heart disease	_____
o Birth defects	_____	o Paralysis/Neurological disorder	_____
o Juvenile arthritis	_____	o Eczema or other skin condition	_____
o Diabetes	_____	o Syphilis	_____
o Kidney disorder	_____	o Epilepsy	_____
o Alcoholism	_____	o Gonorrhea	_____
o Cancer	_____	o Tuberculosis	_____
o Gout	_____	o Other: _____	_____

Do either of the parents have a chronic illness? ☐ No ☐ Yes Please specify: _____

	Age	Health conditions
Mother		
Father		
Sisters		
Brothers		
Grandparents		

Environment

Does the child attend: ☐ School ☐ Daycare ☐ Home care ☐ Other: _____

What are you child's favourite activities? _____

Does the child exercise regularly? o No o Yes Please specify type of exercise: _____
How often and for what duration? _____

How much television does your child watch per week? _____

How often does your child read (not for school), or is read to by someone?
☐ Daily ☐ Several times a week ☐ Weekly ☐ Less than weekly

How would you describe the emotional climate of the child's home: _____

Toxin Exposure

Does anyone in your child's household smoke?	☐ Yes ☐ No
Are there any animals in your child's home?	☐ Yes ☐ No
Has your child ever been exposed to mold, solvents, lead paint, heavy metals, fumes or other toxic substances at home, at school or while traveling ?	☐ Yes ☐ No
Has your child ever experienced health problems after putting down new carpeting, painting your home, doing renovations or having your lawn sprayed with herbicide?	☐ Yes ☐ No
Is your child particularly sensitive to perfume, gasoline or other vapors?	☐ Yes ☐ No
Has your child ever lived near a refinery or a polluted area?	☐ Yes ☐ No
Has your child ever lived in a home more than 50 years old?	☐ Yes ☐ No
Do you believe your child has been exposed to mercury (e.g. playground, dental fillings)?	☐ Yes ☐ No
Does your child have any surgical implants (cosmetic, medical)	☐ Yes ☐ No
Does your child live near power lines?	☐ Yes ☐ No

Review of Systems

Please list any conditions that your child currently or has previously experienced in each of the following body systems:

SKIN (eg. eczema, psoriasis, hives, rashes)

HEAD (eg. headaches)

EYES (eg. itching, pain, infection, corrective lenses)

EARS (eg. wax, discharge, hearing impairment)

NOSE (eg. sinus problems, pain, nose bleeds)

MOUTH (eg. difficult dentition, cavities, loss of taste, problems swallowing)

NECK (eg. stiffness, tenderness, hoarseness, tonsillitis, swelling)

HEART (eg. rheumatic fever, murmurs, chest pain)

NEUROLOGICAL (eg. seizures, paralysis, clumsiness, memory, vision changes, speech problems, sensation alteration)

Toxin Exposure

LUNGS (eg. cough, asthma, wheezing)

_____

GASTROINTESTINAL (eg. vomiting, swallowing, diarrhea, constipation)

_____

URINARY (eg. pain, increased frequency, blood)

_____

MALE (eg. hernias, pain or masses in scrotum/testes)

_____

FEMALE (eg. urgency, menstruation/menarche, discharge, pain or masses in ovaries/uterus)

_____

MUSCLE AND SKELETON (eg. joint pain, stiffness, weakness, back pain, fractures)

_____

Is there anything you feel is important to note that has not been covered in this questionnaire?

_____
_____
_____
_____
_____

Thank you for answering all the questions.
Complete answers to all of the questions are to your benefit for the most effective naturopathic treatment.

This is a confidential record of your medical history. Information contained here will not be released to any person except when you have authorized us to do so.