HOLISTIC HEALTH NIAGARA

8 Capri Circle, St. Catharines, ONT, L2T 3X5
Phone 289-969-0285
Email: Lilyharb@aol.com

CHILD INTAKE

Today's Date__________________

Full Name of Parent or primary caregiver authorized to care for the child ________________________

Child's Name______________ Date of Birth_____________________ Age_______ Sex________

Address____ ____

Phone Number__________________ Email Address_______________________

Emergency Contact__________________ Relation____________________ Phone Number___________________

Referred By____________________

Other Health Care Providers:

1._______________________ 2.__________________________ 3.____________________________

_______________________ __________________________ ____________________________

( )_____________________ ( )_______________________ ( )__________________________

What are your health concerns regarding your child, in order of importance?

1. ____
2. ____
3. ____
4. ____
5. ____

Was your child premature? _____ If so how by how much?_____________________________ Was there any complication during delivery or pregnancy?________________________________

Was mother taking any medication during pregnancy? If so what kind and for how long? ________________________________

Has your child had any organs removed? If yes, please describe which organ and approximate date.____________________________

Nutritional and Lifestyle

Is your child vegetarian?______ How many meals per day does he/she have ______

Does he/she consume tuna?_____ If so, how often_______

What kind of water does he/she drink?____________ How much per day?___________

Please circle if you consume the following: Soy, Corn, Cocoa, Canola Oil, Dairy, Aspartame, Sucralose, MSG, food coloring

Does anyone in your household smoke?______ How is your home heated?____

What kind of shampoo does your child use? ____________________ Do you live near power lines?__________________

Do you have animals in the home? Yes____ No____

Has your child had any dental work? What kind (fillings, root canal, pulled mercury fillings, implants)?

____

____

How would you describe the emotional climate of your home?

____

Does your child experienced emotional or physical trauma? If so when and how?

____

____

Please indicate any traumas (emotional or physical), serious conditions, illnesses or injuries and any hospitalizations along with approximate dates:

____

____

____

____

Does your child have any blood disorders, AIDS, HIV, STD's, Hepatitis, TB or any contagious disease? Please circle. Explain.

____

Does your child have any allergies (medicines, environmental, supplements, etc.)?

____

Please list all current medications:_

____

____

____

Please list all current supplements, herbs, homeopathic, etc.:

____

____

____

How many times has your child been treated with antibiotics per year____

Family History

Please indicate what illness run in your family:

Mother____

Father____

Siblings____

Grandparents____

_________________________ ____________________ ____________________

Signature Date Witness