

FAMILY NATUROPATHIC CLINIC
Mark Orbay, B.Sc., N.D.

CHILD INTAKE FORM

Patient Name _____ Sex (circle) Male Female
Date of Birth _____ Place of Birth: _____
Street Address _____
City _____ Province _____ Postal Code _____
Phone _____
Emergency Contact Person and Telephone Number:

Referred by: _____
Mother's Name and Occupation: _____
Father's Name and Occupation: _____
Parents are (circle): Married Separated Divorced Living Together
Grade in School: _____

Has your child been seen by other doctors for the same concern?
Yes / No
Pediatrician's name and telephone number _____

Last time your child had blood work done _____

What are your child's health concerns, in order of importance:
1) _____
2) _____
3) _____
4) _____
5) _____

Please list all surgeries & hospitalizations, along with approximate dates
1. _____
2. _____
3. _____

How would you describe your child's general state of health?
Excellent Good Fair Poor

FAMILY NATUROPATHIC CLINIC
Mark Orbay, B.Sc., N.D.

List all medicines (prescription or from the drugstore) the child is on now,
and has been on in the past:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

List all the supplements the child is taking:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

List all known allergies to foods, drugs, the environment, and animals _____

Previous Medical History

Please circle the correct one for your child.

Ear infections: Yes No Past, if has had, how many times? _____

Colds: Yes No Past, if has had, how many times? _____

Strep Throat: Yes No Past, if has had, how many times? _____

Rubella/German Measles: Yes No

Measles: Yes No

Impetigo: Yes No

Chicken pox: Yes No

Scarlet Fever: Yes No

Mumps: Yes No

Whooping cough: Yes No

Roseola: Yes No

Mononucleosis: Yes No

Vaccination History:

Measles/Mumps/Rubella: Yes No Hepatitis B: Yes No

Diphtheria/Pertussis/Tetanus: Yes No Chicken pox: Yes No

Haemophilus influenza B: Yes No "Flu"/Influenza: Yes No

Hepatitis A: Yes No Other: _____

Reactions to vaccinations? Yes No If yes, what happened: _____

FAMILY NATUROPATHIC CLINIC
Mark Orbay, B.Sc., N.D.

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

Vision tests normal: Yes No Not tested

Hearing tests normal: Yes No Not tested

Speech impediments: Yes No In past

Learning impediments: Yes No In past

Family Health History:

Allergies: Y N Obesity: Y N Cancer : Y N

Diabetes : Y N Tuberculosis : Y N Mental Illness : Y N

Cardiovascular Disease : Y N

Do either of the parents have a chronic illness? If yes, please describe: _____

Pregnancy History:

Age at conception of father _____ and mother _____

Health of father at conception _____

Health of mother at conception and during pregnancy: _____

Did the mother already have other children? _____

Diet of mother during pregnancy: Excellent Good Fair Poor

Did the mother use supplements? Yes No Medications? Yes No

Did the mother smoke? Yes No Use drugs? Yes No Alcohol? Yes No

Experience bleeding? Yes No Have high blood pressure? Yes No

Have nausea? Yes No Vomit? Yes No Have Diabetes ? Yes No

Thyroid problems? Yes No Physical or emotional trauma? Yes No

Length of labour: _____

Vaginal birth? Yes No C-section? Yes No Induced? Yes No

Traumatic birth? Yes No

If the birth was difficult, please explain: _____

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

Health History of Child

Breastfed Yes No If yes, for how long? _____

What kind of formula was used: Milk/Soy/Other _____

FAMILY NATUROPATHIC CLINIC
Mark Orbay, B.Sc., N.D.

When were they put on formula? _____
When did they begin eating solid foods? _____
When did they first begin to crawl? _____ walk? _____
When did they first begin to talk? _____
Develop teeth? _____

Jaundice as a baby: Y N	Colic: Y N
Cradle cap: Y N	Diaper rash: Y N
Eczema and/or Psoriasis: Y N	Asthma: Y N
Diarrhea: Y N	Constipation: Y N
Finicky eater: Y N	Warts: Y N
Poor teeth: Y N	Bed-wetting: Y N
Hyperactivity: Y N	Tantrums: Y N
Nightmares: Y N	Disobedient: Y N
Anemia: Y N	Chronic sniffles: Y N
Stomach pains: Y N	Growing pains: Y N

How would you describe your child's temperament? _____

How would you describe their behavior and performance at school?

What household stressors has your child witnessed or experienced?
1) _____
2) _____
3) _____

How would you describe the emotional climate of your home?

What kind of physical activities do they enjoy? _____

How often do they play outside? _____
How much television do they watch per day? _____
How many hours are they on the computer daily? _____

FAMILY NATUROPATHIC CLINIC
Mark Orbay, B.Sc., N.D.

Do they participate in any religious group? Yes No

Are they active participants? Yes No

What religion do they practice? _____

Toxin Exposure:

Does anyone in the child's home smoke? Yes No

Are there any animals in the house? Yes No What kind? _____

How is your house heated? _____

Has your child ever lived near a factory or polluted area, or in a home with lead paint? If so, what kind of pollution were they exposed to?

Has your child ever lived in a house with new carpeting, paint, cabinets or renovations that seemed to affect their health at all?

Does your child seem especially sensitive to perfumes, gasoline or other vapours? _____

Do you spray pesticides, herbicides, or other chemicals around your home? _____

Thank you for taking the time to fill out this health questionnaire.
It will greatly help in the study of your child's present health concerns and will assist in optimizing their health.