Child Intake Form

Dr. Jennifer R. Strong BSc., ND
Naturopathic Doctor

Walkerville Chiropractic
1275 Walker Road
Windsor, ON N8Y 4X9
ph: 519 258-7979

Name _____ Date _____

Date of Birth _____(M/D/Y) Sex: M / F

Address _____ Town/City _____

Postal Code _____ Email Address _____

Mothers Name _____ Fathers Name _____

If parents are separated, child lives with _____

Phone # (home) _____ (other) _____

May we leave messages relating to your child's visits? Y / N

How did you hear about Dr. Strong? _____

Please note that supplements may be prescribed to you to improve your health condition, and they can be purchased from our in-house dispensary, or elsewhere.
Kindly give 24 hours notice if you need to cancel or reschedule your appointment; otherwise a cancellation fee of $25.00 will be applied to your account.

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.
A number of different approaches may be used throughout the course of treatment. Treatment modalities include diet, lifestyle counselling, clinical nutrition (AKA supplementation), botanical medicine, homeopathy, acupuncture, hydrotherapy, and physical medicine.
I acknowledge that my Naturopathic Doctor, Jennifer Strong, may be required to perform certain diagnostic techniques, such as a physical exam, orthopedic tests, laboratory tests, or history taking.

Signature: _____

Extended health Care:
1) Plan name:_____ policy #_____ member ID:_____
2) Plan name: _____ policy #_____ member ID:_____

Please note that only Greenshield will be billed directly; all other plans require you to pay up front and then submit the receipt to your respective insurance company.
Please note you are responsible for any fees that are not covered by your extended health care provider, and that these fees are due at the time of consultation.

Main Health Concern:

_____
_____
_____

How long has this condition persisted?_____

Previous treatments and results:_____

Other health concerns, in order of importance to you:
1._____
2._____
3._____

Other health care providers you are seeing:
1._____ 2._____ 3._____
_____ _____ _____
(____)_____ (____)_____ (____)_____

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

Please indicate any serious conditions, illnesses, injuries, or hospitalizations, along with dates:

_____ _____
_____ _____
_____ _____

Do you have any allergies (medicines, environmental, food, etc.)?

_____ _____
_____ _____
_____ _____

Please list all current medications (over the counter and prescribed), and supplements:

_____ _____
_____ _____
_____ _____

Immunizations :

Polio	Y N	Pertussis	Y N
Tetanus shot	Y N	Diphtheria	Y N
Measles/ Mumps/ Rubella	Y N	Influenza	Y N

Any adverse reactions? Y N If yes, what? _____

Does your child get regular screening tests done by another doctor (allergy testing, blood tests, etc.)? Y / N

Does your child have any dietary restrictions? _____

How many days per week does your child eat fast food? _____

How long was your child breast fed? _____

Describe a typical day's diet:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages: _____

How often does your child have a bowel movement? _____
Please describe its appearance: _____

How often does your child urinate per day? _____
How often does your child experience gas/ belching? _____

Family History:
Indicate if a close relative (parent/ child/ sibling) has had any of the following:

	Who?		Who?
Allergies		Depression	
Arthritis		Other mental illness	
Asthma		Drug/ alcohol abuse	
Heart disease		Thyroid condition	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes		Other	

- I don't know my family history.

Is your child involved in any extracurricular activities?_____

How many hours of sleep does your child get at night? _____
Does your child wake during the night? Y / N If yes, at what time? _____

How would you describe the emotional climate of your home? _____
_____

Is your child currently in daycare? _____
Do you have any concerns regarding his/ her daycare? _____

Please describe your child's behavior on a regular basis: _____
_____

Is there anything that you feel is important that has not been covered?
_____
_____
_____