

# Child Intake Form (age 12 and under)

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

**Walkerville Chiropractic**  
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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? \_\_\_\_\_

Fee Schedule: Initial Child Visit: (1hr) \$125 2<sup>nd</sup> Visit (1hr): \$100  
Follow-up Visits: \$60 Blood work: fee varies

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.

Extended health Care: If you would like us to bill your Extended health care plan please fill out information here, or provide us with your card to copy.

Plan name: \_\_\_\_\_ policy # \_\_\_\_\_ member ID: \_\_\_\_\_

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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.

Parents Signature: \_\_\_\_\_

**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 :**

DTPHib Y N MMR Y N chickenpox Y N

Annual flu shot Y N Rotavirus 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?  
\_\_\_\_\_