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### Holistic Nutrition, Child Intake Form

Name: \_\_\_\_\_  
(First) (Initial) (Last)

Address: \_\_\_\_\_  
(Street) (City) (Postal Code)

Parent/Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male  Female   
(Month/Day/Year)

How did you find out about our clinic? \_\_\_\_\_

If referred, please provide name of referee (so we can thank them): \_\_\_\_\_

Would you like to receive the clinic e-mail newsletter? Yes  No

#### **Emergency Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Doctor: \_\_\_\_\_  
(Given) (Surname)

## LIFESTYLE ASSESSMENT – PEDIATRIC

Please answer each of the following questions; use the back of the page if necessary.

What is your purpose in coming here today?.....  
.....

What are your child's main health concerns / complaints?  
.....  
.....  
.....

### Symptoms (mark C for current and P for past, blank if inapplicable):

Hives ..... Eczema .....Chronic rash ..... Hair loss .....Cough.....  
Excessive fatigue ..... Bed wetting ..... Sore throat ..... Frequent colds.....  
Canker sores .....Burning urination ..... Cries easily ..... Sleep problems.....  
Nightmares .....Night sweats .....Walks in sleep .....Talks in sleep .....  
Bruises easily ..... Dizzy spells .....Whizzing .....Anemia ..... High fevers .....  
Blood in urine .....Stomach aches .....Constipation .....  
Diarrhea..... Gas..... Change in appetite .....No appetite .....Vomiting spells .....  
Jaundice..... Bleeding gums .....Nose bleeds .....Nervous.....  
Sensitive to light..... Bad breath .....Body odour .....Motion sickness .....  
Frequent headaches.....Joint pains .....Flat feet ..... Hearing loss .....  
Heart murmur.....

### Medical History (Please circle):

Frequent cold, Allergies, Tonsillitis, Ear infections, Rheumatic fever, Chickenpox, Measles, Mumps, Rubella, Scarlet fever, Pneumonia.  
Other.....

Has your child had any recent blood tests? (Results):.....

Has he / she ever been hospitalized for any reason?  
.....

How often does he/she have a bowel movement? ..... Does he/she strain to have a BM? ..... Does he/she have any loose BM? ..... Related to any particular food or circumstances? .....

What is your child's level of physical activities?.....

What are his /her preferred playtimes? .....

How is he/she doing at playschool / preschool/ grade school?

.....  
.....

*For office use only*

**Medications:**

Aspirin..... Tylenol.....Decongestant ..... Antibiotics.....

Anti-histamines..... Ibuprofen.....

Other.....

Nutritional supplements (please list names & amount):.....

Do you know of any drug allergies? .....

Any other allergies .....

**Immunizations (please circle):**

Measles, Polio, Smallpox, Influenza, Mumps, Tetanus, Hepatitis A or/and B, Diphtheria.

Any reactions? .....

**Mother's health during pregnancy (please circle):**

Bleeding, Nausea, Cigarettes, Alcohol and/or Drug consumption, Diabetes, Hypertension, Thyroid problems, Illnesses, Physical or Emotional trauma?.....

Term: Full.....Premature.....Late.....

Weight at birth: .....

Has your child had any of the following problems as newborn (please circle)?

Jaundice, "Blue Baby", Colic, Diarrhea.

**Dietary habits:**

**How many ½ cup servings does he/she typically eat in a day?**

Fruits? Fresh..... Dried ..... Canned .....  
Vegetables? Raw .....Cooked .....Canned .....  
Whole grains: ..... Types: .....  
Dairy: .....Types:.....  
Protein sources: .....  
Other, please specify: .....

**Please indicate how many cups of the following he /she drink per day:**

Bottled water ..... Tap water .....Milk (%) .....  
Fresh fruit juices ..... Prepared fruit juices .....  
Soft drinks (regular)..... Diet soft drinks ..... Other .....

**Give examples of his /her typical meal:**

Breakfast:

.....  
.....  
.....

Lunch:

.....  
.....  
.....

Dinner:

.....  
.....  
.....  
.....

Snacks (with times):

.....  
.....  
.....  
.....

What are his /her favourite foods?

.....

How often does he /she eat them? .....

## Holistic Nutrition Client Disclaimer and Care Agreement

I have been informed that Effective Health Solutions is the management company providing management services to the individual practitioners at the clinic. I further acknowledge that Effective Health Solutions shall not be liable for any grievances, arising directly or indirectly, as a result of or in connection with my treatment provided by individual practitioners at the clinic.

I understand and acknowledge that the services provided are at all times restricted to consultation on the subject of health matters intended for general well-being, and are not meant for the purposes of medical diagnosis, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. I understand that the ultimate responsibility for my health care is my own, and that the Holistic Nutritionist is here to support me in this.

This statement is being signed voluntarily.

Date: \_\_\_\_\_

Signature (Guardian): \_\_\_\_\_

Name (please print): \_\_\_\_\_

*All information contained will be kept strictly confidential.*