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holly giannatselis
NATUROPATHIC DOCTOR

Intake Form
Note: This record is confidential. The information helps in providing you with the best healthcare possible.

Name:_____ **Date:**_____

Date of Birth:_____ **Gender:** ☐ Male ☐ Female ☐ Transgender

Address:_____**City:**_____**Province:**_____**Postal Code**:_____

Telephone Numbers: Home:_____ **Cell:**_____ **Work:**_____

May we leave messages relating to your visits: ☐ Yes ☐ No **Which Phone Number:**_____

Email Address:_____

Emergency Contact:_____ **Relation:**_____**Phone Number:**_____

Marital Status: ☐ Single ☐ Married ☐ Separated/Divorced ☐ Widowed

Nationality _____

Have you ever consulted any of the following (Please check all that apply):
☐ Naturopath ☐ Acupuncturist ☐ Nutritionist ☐ Counselor
How did you hear about this clinic?

Health Goals_____
What are your health concerns and goals? List in order of importance to you.

Please list most important health concerns and goals in their order of significance	***Prior diagnosis of the health concern? If so, what was it?***
1.	
2.	
3.	

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Pediatric Intake Form

Medical Information

Which of the following has your child had? (N-Never, M-Mild, A-Average, S-Severe)

N M A S *Rubella*	**N M A S** *Roseola*	**N M A S** *Impetigo*
N M A S *Measles*	**N M A S** *Scarlet Fever*	**N M A S** *Mononucleosis*
N M A S *Chicken Pox*	**N M A S** *Whooping Cough*	**N M A S** *Ear Infections*
N M A S *Mumps*	**N M A S** *Strep Throat*	

What screening tests has your child had (blood, vision, hearing, etc.)? List in the box below.

Prenatal Health

What was the age of the mother at child's birth? _____What was the age of the father at child's birth? _____

What was the health of the parents at conception?
Mother ☐ Poor ☐ Fair ☐Good ☐Excellent ☐ Unknown
Father ☐ Poor ☐ Fair ☐Good ☐Excellent ☐ Unknown

What was the health of the mother during pregnancy? ☐ Poor ☐ Fair ☐Good ☐Excellent ☐ Unknown
How was the mother's diet during pregnancy? ☐ Poor ☐ Fair ☐Good ☐Excellent ☐ Unknown
Did the mother receive prenatal care? ☐ Yes ☐ No ☐ Unknown

Did the mother experience any of the following during pregnancy? Check all that apply.
☐ Bleeding ☐ High Blood Pressure ☐ Nausea ☐ Vomiting
☐ Diabetes ☐ Thyroid Problems ☐ Physical or emotional trauma

Did the mother use any of the following during pregnancy? Check all that apply.
☐ Tobacco ☐ Alcohol ☐ Recreational Drugs:_____

☐ Prescription medications:_____

☐ Over the counter medications:_____

☐ Supplements:_____

☐ Other:_____

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Birth History_____

Term Length: ☐ Full ☐ Premature: _____ weeks ☐ Late:_____ weeks

Length of labour:_____ **Weight at birth**:_____ **Length at birth**:_____

Any complications? ☐ Yes ☐ No **If so, please list**:_____

Was the birth: ☐Vaginal ☐C-Section ☐ Induced ☐ Anesthesia used ☐ Forceps

Did the child experience any of the following at or shortly after birth?

☐ Jaundice ☐ Rashes ☐ Seizures ☐ Birth injuries:_____

☐ Birth abnormalities: _____

☐ Other:_____

Dietary Information_____

How was your infant fed? ☐ Breastfed; How long?_____ ☐ Formula ☐ Milk/Soy/Other:_____

What foods were introduced at the ages listed below? Please list approximate month as well.

	Food(s)	Age
Before 6 Months		
Between 6-12 Months		

Did your child ever experience colic? ☐ Yes ☐ No **If so, how severe?** ☐ Mild ☐ Moderate ☐ Severe

Environment_____

Is the child in: ☐ School ☐ Daycare ☐ Homecare ☐ Other:_____

What are your child's favourite activities?

- -
- -
- -

How much time with electronics does your child have? _____ hours a day/week

Does your child exercise regularly? ☐ Yes ☐ No **If yes, complete chart below.**

Exercise	How Much	How Often