brio LIVING™

CHILD (0-12 yr) INTAKE FORM

Date ____________________

First name ____________________ Last name ____________________

Age ____________ Date of birth (mm/dd/yy) ____________ Female/Male ____________

Care Card # ____________________

Mother's name ____________________ Father's name ____________________

Address ____________________ City/ Province ____________________

Postal code ____________________ Parent's email ____________________

Phone (home) ____________________ Phone (work) ____________________

How did you hear about the clinic? ____________________

HEALTH HISTORY QUESTIONNAIRE

What are your child's most important health problems? List as many as you can in order of importance.

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________

Does your child have a contagious disease at this time? ◯ Y ◯ N

If yes, what?

____

CANCELLATION POLICY

I understand that I am responsible for paying the cost of the visit, before the next appointment, if I do not give 24 hours notice by phone of change or cancellation. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

CONSENT

I hereby consent for my child to receive treatments by the practitioners at Brio Integrative Health Centre. I understand that this consent is voluntary and may be revoked by me at any time. I authorize the clinic and its associated practitioners to collect personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contacted numbers I have provided.

I consent to receiving ◯ phone calls/messages from Brio ◯ email messages from Brio

Please add me to the newsletter list. ◯ Y ◯ N

Signature (Parent or Guardian) ____________________ **Date** ____________

GENERAL

Current Height/Length ____________________ Current Weight ____________________

Weight at birth ____________________ Length at birth ____________________

Child's Apgar score (0-10) ____________________ Child's religion ____________________

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

What screening tests has your child had (blood, hearing, vision, etc.)? ____________________

DIET

How was your infant fed? ◯ Breastfed ◯ Formula

Breast fed for how long? ____________________

Formula fed ◯ Cow's Milk ◯ Soy ◯ Other (Please specify) ____________________

What foods were introduced before 6 months? (Please list approximate months as well) ____________________

____

6-12 months? ____________________

Did your child ever experience colic? ◯ Y ◯ N How severe? ____________________

Does your child have any dietary restrictions (religious, vegetarian/vegan etc.)? ____________________

MEDICAL HISTORY

Rheumatic fever	◯ Y	◯ N		German measles	◯ Y	◯ N	
Chicken pox	◯ Y	◯ N		Measles	◯ Y	◯ N	
Tonsillitis	◯ Y	◯ N	approx. number ______	Ear infections	◯ Y	◯ N	approx. number ______
Other	◯ Y	◯ N					

(Please list) ____________________

____

FAMILY HISTORY

Is there a family history of any of the following?

Cancer	◯ Y	◯ N	Diabetes	◯ Y	◯ N	Heart disease	◯ Y	◯ N
Kidney disease	◯ Y	◯ N	Epilepsy	◯ Y	◯ N	High blood pressure	◯ Y	◯ N
Tuberculosis	◯ Y	◯ N	Stroke	◯ Y	◯ N	High cholesterol	◯ Y	◯ N
Asthma/Hay fever/Hives	◯ Y	◯ N	Arthritis	◯ Y	◯ N	Anemia	◯ Y	◯ N

Any other relevant family history? ____________________

What is the child's ethnic heritage? ____________________

HOSPITALIZATIONS/ SURGERIES/ INJURIES

What hospitalizations, surgeries or injuries has your child had?

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 ?

TYPICAL FOOD INTAKE

Breakfast

Lunch

Dinner

Snacks

Beverages

Please list any prescription medications, over the counter medications, vitamins or other supplements your child is taking

1.

2.

3.

4.

5.

6.

7.

8.

BIRTH MOTHER'S PRENATAL HISTORY

Mother's age at child's birth?

Mother's health during pregnancy?

Were any of the following experienced during pregnancy?

Bleeding	◯ Y	◯ N	Physical/Emotional trauma	◯ Y	◯ N	High blood pressure	◯ Y	◯ N
Nausea/Vomiting	◯ Y	◯ N	Thyroid problems	◯ Y	◯ N	Cigarettes/Alcohol/Drugs	◯ Y	◯ N
Illnesses	◯ Y	◯ N	Medications	◯ Y	◯ N	Gestational diabetes	◯ Y	◯ N

Did the mother use any of the following during the pregnancy?

Tobacco	◯ Y	◯ N	Alcohol	◯ Y	◯ N	Recreational drugs	◯ Y	◯ N
Prescription medication	◯ Y	◯ N	Over-the-counter medication	◯ Y	◯ N	Supplements	◯ Y	◯ N

Other

CHILD'S BIRTH HISTORY

Term ◯ Full ◯ Premature ______ weeks ◯ Late ______ weeks

Weight at birth ______ Length of labour ______

Any complications? ______

Birth ◯ Vaginal ◯ C-section ◯ Induced ◯ Forceps ◯ Anesthesia used

Did your child have any of the following problems shortly after birth?

Birth abnormality	◯ Y	◯ N	Birth injuries	◯ Y	◯ N	Blue baby	◯ Y	◯ N
Cerebral palsy	◯ Y	◯ N	Seizures	◯ Y	◯ N	Jaundice	◯ Y	◯ N
Colic	◯ Y	◯ N	Fever	◯ Y	◯ N	Rashes	◯ Y	◯ N

Other (explain) ______

Child's sleep patterns ______

How would you describe your child's temperament? ______

REVIEW OF SYMPTOMS

Pleas mark with the following: Y = a condition now P = significant problem in the past

____	Hives	____	Burning of urine	____	Bloody Urine
____	Eczema	____	Frequent urination	____	Cries Easily
____	Bleeding gums	____	Heart murmur	____	Nervous
____	Nose bleed	____	Vomiting spells	____	Sleep problems
____	Acne	____	Anemia	____	Night sweats
____	High fevers	____	Stomach aches	____	Sensitive to light
____	Chronic rash	____	Jaundice	____	Body/breath odor
____	Hearing loss	____	Easy bruising	____	Motion/car sickness
____	Diarrhea	____	Flat feet	____	No appetite
____	Sore throats	____	Constipation	____	Nightmares
____	Headaches	____	Gas	____	Canker sores
____	Frequent colds	____	Bleeding tendency	____	Unusual fears
____	Wheezing	____	Joint pains	____	Excessive fatigue
____	Cough	____	Dizzy spells	____	Hair loss

Is there any information about your child’s health that you would like to add? ______

______

What expectations do you have for your child from working with our clinic? ______

______

Welcome! We’re honored to be of service for you and your child!