vitallife
integrative medicine

Today's Date (MM/DD/YYRR): _____

Practitioner (please select):

☐ Cheryl Cooper, ND ☐ Katrina Ostafichuk, ND
☐ Erin Whyte, RMT ☐ Irma Boyle, Doctor of Medical Heilkunst, Homeopathy
☐ Heather Resvick, RHN, ROHP

Name: _____

Address: _____

_____

City: _____Province: _____

Home Phone #: _____

Cell #: _____

Office # _____ extension: _____

Preferred contact method? ☐ Home # ☐ Cell # ☐ Work # ☐ Email

Email: _____

Sex: M_____ F_____ Birthdate (MM/DD/YYRR):_ _____

How did you hear about us? _____

Office Use

☐ Status to Active ☐ Cancellation Policy in Notes
☐ Practitioner Selected ☐ Referral Method

Pediatric Intake Form

Please fill out the following information as completely and accurately as possible as it will enable us to provide the best care for your child.

Child Information

Child's Name_____ male or female
Date of Birth_____ Age _____
Address_____Postal Code_____
Phone Number_____

Parents/Family Information

Mother's Name_____
Phone Number at Home _____ Work/Cell _____
Father's Name_____
Phone Number at Home _____ Work/Cell _____
Parent's Marital Status_____
Child's Living Arrangements_____

Siblings

Name_____Age _____
_____ _____
_____ _____
_____ _____
_____ _____

Other Primary Health Caregivers (Doctors, Chiropracters, etc.)

Name_____Phone Number_____
Name_____Phone Number_____
Ethnic Background_____
Religious/Spiritual Beliefs_____

Major Concerns (In order of importance.)

1. _____
2. _____
3. _____
4. _____
5. _____

With respect to your primary concern, has your child received treatment previously?
Yes / No
If so, what was the treatment?_____
_____

Medical History

Preconception

Mother's Health poor 1 2 3 4 5 excellent
Father's Health poor 1 2 3 4 5 excellent
Fertility Drugs/Interventions_____

Prenatal (during the pregnancy)

Mother's Health poor 1 2 3 4 5 excellent
Any stress, illnesses or complications during the pregnancy?_____
_____
Weight Gain _____

Please indicate whether you took or were exposed to any of the following medications, supplements or toxins during your pregnancy, including frequency and amounts:
Medications_____
Supplements_____
Alcohol_____
Cigarette Smoke_____
Recreational Drugs_____
Environmental Toxins_____

Birth/Delivery/Infancy
Length of Pregnancy (weeks)_____
Delivery home hospital other _____
Type of Birth vaginal cesarean forceps vacuum
Anaesthetic/Painkillers Used?_____
Other Interventions/Problems?_____
How would you describe your birth experience?_____
_____
Birth Weight_____Birth Length_____
Any health problems at birth?_____
Within the first 4 weeks?_____
Sleep Patterns_____
Please check off any of the following which apply to your child:
Jaundice _____
Colic _____
Vomiting _____
Constipation _____
Restlessness _____
Diaper Rashes _____
Other Illnesses _____
Was the child breastfed? Yes / No If so, for how long?_____
If formula fed, what kind of formula?_____
Does the child consume dairy?_____From what age?_____
At what age were solids introduced?____
Did you notice any adverse reactions to foods or changes in the child's bowel habits or moods with certain foods? Yes / No If yes, please list_____
_____
At what age did the child walk?_____talk?_____
Were there any significant developmental difficulties? Yes / No If yes, please specify _____

Medical History
Past Illnesses/Medications
Please check any of the following illnesses which your child has had or currently has and indicate the age which the illness occurred or began:
__Croup_____ __Allergies_____ __Eczema_____
__Asthma_____ __Chicken Pox_____ __Strep Throat__
__Cold/Flu_____ __Ear Infections_____ __Measles_____
__Mumps_____ __Rubella_____ __Rashes_____
__Whooping Cough_____ __Scarlet Fever_____
Please list any significant illnesses/surgeries/traumas since birth?_____

Medications or treatments received?_____
_____
How many time has your child taken antibiotics?_____
For what and when?_____
_____
Does your child have any strong dietary preferences or aversions?_____
_____
Is your child vegetarian? Yes / No
How does your child sleep?_____
Does he/she remember her dreams?_____
Does your child ever seem excessively sad or upset by situations?_____
_____
Does your child ever display anger or agression towards others?_____
_____
How would you rate your child's general energy level?
Low 1 2 3 4 5 6 7 8 9 10 High
How would you rate your child's stress level?
Low 1 2 3 4 5 6 7 8 9 10 High
How many hours per week does your child watch TV?____
How many hours per week does your child spend on the computer?___
How many hours per week does your child spend playing video games (Nintendo, Gameboy, etc.)?___
What hobbies or sports does your child participate in?_____
_____
____

Family History
Mother's Age___
General Health poor 1 2 3 4 5 excellent
Father's Age___
General Health poor 1 2 3 4 5 excellent
Siblings Ages_____
General Health poor 1 2 3 4 5 excellent
How would you rate the stress level in your house? (please circle)
Low 1 2 3 4 5 6 7 8 9 10 High

Vaccinations (please check off and indicate age given)
__Diptheria_____ __Pertussis_____
__Tetanus_____ __Polio_____
__Measles_____ __Mumps_____
__Rubella_____ __Chicken Pox_____
__Influenza_____ __Small Pox_____
__Hepatitis_____ Other_____
Did you notice any adverse reactions or illnesses following the vaccinations? Yes / No
If yes, please give more details_____
_____
Please indicate the incidence of any of the following illnesses in the family and the relation to the child:
__Cancer_____
__Diabetes_____

__Heart Disease_____
__Respiratory Disease/Asthma_____
__Allergies_____
__Skin Problems_____
__Kidney Disease_____
__Blood Disease_____
__Digestive Disease_____
__Genetic Abnormalities_____
__Mental Illnesses_____
Other significant family illnesses_____

Social History

Outline your child's daycare and school history from:
Birth-4 years old_____
4 years old-present_____
_____
Current Grade_____
Has your child ever disliked going to daycare or school? Yes / No
If yes, why?
_____
_____
Does your child have friends? Yes / No
Does your child make friends easily? Yes / No
Please rate the following aspects of your childs current development:

	Below Average	Average	Above Average
Speech	1	2	3
Writing	1	2	3
Reading	1	2	3
Physical Skills	1	2	3
Mental Development	1	2	3
Emotional State	1	2	3

Please use the space below to give any other information pertinent to your child's health.
_____
_____
_____
_____
_____
_____
Thank You!

Adolescent Intake Form

This form is to be filled in by the adolescent (13-18 years) and is confidential.

Major Concerns

1. _____
2. _____
3. _____

How is your energy level?

Low 1 2 3 4 5 6 7 8 9 10 High

Do you like school? Yes / No

If no, why not?_____

What are your favorite subjects at school?_____

_____

What sports, activities or hobbies do you have?_____

_____

What do you like to do in your spare time?_____

_____

If there was anything about yourself that you could change what would it be?_____

_____

How is your relationship with your parents/family?_____

_____

Menstrual History (if applicable)

Age of Menarche_____

Length of Cycle (days it lasts)_____

Regularity(how often) _____

Pain (when, how much, type, where)_____

_____

Discharges (quantity, color, quality)_____

_____

Sexual History

Dating Yes / No Since_____

Sexually Active Yes / No Since_____

Condoms Yes / No

Birth Control Yes / No Type_____

Masturbation Yes / No Frequency_____

How you ever had an STD? Yes / No

If yes, what and when?_____

Substance Use

Tobacco Yes / No Since_____

Alcohol Yes / No Since_____

Recreational Drugs Yes / No Type_____

Would you prefer to see the doctor: Alone With Parents Any