Carp Ridge EcoWellness Centre
4596 Carp Road, Carp ON. K0A1L0

Phone: 613-839-1198 Fax: 613-839-3909
info@ecowellness.com www.ecowellness.com

Child Intake Form

Date: _____

Name: _____ Date of birth: _____

Gender: _____ Person filling out form: _____

Parent's Name: _____

Parent's Name: _____

Legal Guardian: _____

Main Address: _____

Main Phone numbers/names:

_____

_____

Main email addresses:

_____

_____

Who referred you to our clinic? _____

Chief concerns:

_____

_____

Gestation period influences: (pls circle) coffee alcohol cigarettes stress grief drugs (recreational or prescription) very good time other: _____

Birth: (pls circle) anesthetic forceps C-section stress medications complications vaccines very good experience lots of caring support other: _____

Apgar score: _____ Weight: _____

Please describe any complications:

_____

_____

Infancy: breast-fed for how long and any complications:

_____

_____

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Symptoms: (circle) difficult teething poor weight gain colic sleeping difficulties low appetite very clingy motor skill issues balance language problems behavioural problems eating habits other:

_____

_____

Vaccinations and how tolerated:

_____

_____

Other: _____

Age of: sitting up _____ walking _____ talking _____ first solid food _____

What foods were given: _____

Any trauma/shocks in the first year: _____

Daycare situation before school and how it was tolerated:

_____

_____

Family situation at home, mention any stresses:

_____

_____

Siblings: _____

Pets: _____

How did child respond to going to school: _____

Any difficulties at school? _____

Current diet: (circle) normal whole food vegetarian vegan other: _____

Supplements/medications:

_____

_____

Current sleep patterns: _____

Current activity level: _____

Current stressors and how the child is responding:

_____

_____

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Allergies: _____

Head injuries/seizures/high fevers?

Strong emotions: (circle) anger rage grief depression jealousy shame self-devaluation suicidal

Primary care physician: _____

Hospitalizations: _____

Treatments/practitioners the child has seen and how effective they were:

_____
_____
_____
_____

Family History:

Appearance of parents (build, skin colouring, hair texture/colour, glasses, eye colour):

Mother: _____

Father: _____

Health problems:

Mother: _____

Father: _____

Other members of the family that have a significant medical condition:

_____
_____
_____

Environmental toxin exposure? _____

Hours watching screens/day average: _____

Religious or spiritual context/beliefs in the family:

_____
_____

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Please mark symptoms with the appropriate letter. If the symptom does not apply, please leave it blank.

C: Currently (past 3 months) **F:** Frequently (3-4 x per week) **O:** Occasionally (up to 2x per week) **P:** Past

Current Weight: _____ Weight 1 year ago: _____ Height: _____

General:
____ energy: hi, med,low
____ fatigue
____ fever
____ chills
____ frequent colds
____ night sweats
____ chronic pain

Skin:
____ acne
____ boils
____ changes in moles
____ colour change
____ dry skin
____ eczema/dermatitis
____ hives
____ itching
____ lumps
____ nail changes
____ frequent rashes
____ skin cancer

Blood:
____ abnormal blood test
____ bleed/bruise easily
____ anemia
____ allergies

Nose & Sinuses:
____ frequent colds
____ nasal stuffiness
____ hay fever
____ frequent nose bleeds
____ sinus trouble

Head:
____ headache
____ migraines
____ dandruff
____ hair loss (excessive)
____ hair growth (excessive)
____ swollen glands
____ pain/stiffness of neck

Eyes:
____ poor vision
____ glasses/contacts
____ sensitive to light/sun
____ pain
____ redness
____ dry eyes
____ itching
____ discharge
____ excess tearing
____ double vision
____ infections
____ last eye exam

Ears:
____ poor hearing
____ ringing in ears
____ dizziness
____ earaches
____ infection
____ discharge
____ excess ear wax
____ feeling of fullness

Mouth & Throat:
____ multiple cavities
____ root canals
____ poor gums
____ sore tongue
____ cold/canker sores
____ coated tongue
____ hoarseness
____ frequent sore throat
____ bitter taste in mouth
____ loss of taste
____ last dental exam

Respiratory:
____ persistent cough
____ sputum
____ wheezing
____ shortness of breath (SOB)
____ SOB lying down
____ SOB on exertion
____ last chest x-ray
____ difficulty breathing
____ persistent infections
____ spitting up blood

Heart:
____ high/low blood pressure
____ angina
____ heart murmurs
____ swollen ankles
____ chest pain
____ palpitations
____ rheumatic fever

Peripheral Vascular:
____ cold hands/feet
____ cyanosis (skin appears blue)
____ extremity numbness
____ extremity swelling
____ extremity skin ulcers
____ haemorrhoids
____ leg cramps
____ leg pain worse exercise
____ lymph node swelling
____ numbness or tingling
____ Raynaud's syndrome
____ varicose veins
____ wounds slow to heal

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Urinary:
____ # of urinations/day
____ urination at night
____ blood in urine
____ pain on urination
____ urgency
____ frequent infections
____ incontinence
____ kidney stones
____ dribbling

Endocrine:
____ change in thirst
____ change in hunger
____ cold/heat intolerance
____ excessive sweating
____ diabetes
____ recent weight gain
____ recent weight loss
____ seasonal depression
____ thyroid problems
____ thinning eyebrows
____ goitre

Nervous System:
____ fainting/blackouts
____ paralysis
____ local weakness
____ tremors
____ memory difficulties
____ strokes

Gastrointestinal:
____ difficulty swallowing
____ heartburn
____ persistent nausea
____ appetite up or down
____ persistent vomiting
____ vomiting blood
____ indigestion
____ rectal bleeding
____ change in bowel movements
____ pale stool
____ black stool
____ undigested food in stool
____ small/thin stool
____ mucus in stool
____ constipation
____ diarrhoea
____ abdominal pain
____ difficulty skipping meals
____ food intolerances
____ food cravings
____ excessive belching
____ excessive bloating
____ excessive passing gas
____ haemorrhoids
____ jaundice
____ gallstones
____ gallbladder removed?
____ worse eating fatty foods?
____ hepatitis

Muscoloskeletal:
____ joint pains
____ stiffness
____ joint swelling
____ arthritis
____ muscle pain/ cramps
____ backache
____ gout
____ broken bones

Male:
____ discharge from penis
____ sores on penis
____ hernias
____ testicular pains
____ masses

Mind / Emotion:
____ nervousness
____ tension
____ mood swings
____ depression/anxiety
____ lack of concentration
____ foggy thinking
____ excess anger/sadness/ mania/frustration/difficulty expressing emotions

THANK YOU!