INTAKE FORM FOR YOUNG CHILDREN

Date of intake:

Name:

Age:

Date of Birth:

Mothers Health during Pregnancy

Disease processes:

Medication taken:

Smoke:

Alcohol consumption:

Patient's Birth/Childhood History:

Were there any pregnancy or birth complications

Were you:

Born term

Breast-fed	How long
Bottle-fed	Type of formula

Age of introduction of:

Solid food	Wheat	Dairy

Vaccinations

Current Health Concerns

1.
2.
3.
4.
5.

Allergies

1.
2.
3.
4.

Lifestyle Review:

Diet

Please record what you eat in a typical day:

Breakfast

Lunch

Dinner

Snacks

Fluids

How many servings do you eat in a typical week of these foods:

Fruits (not juice)

Vegetables (not including white potatoes)

Legumes (beans, peas, etc)

Red meat

Fish

Dairy/Alternatives

Nuts & Seeds

Fats & Oils

Do you consume:

Cans of soda (regular or diet)

Sweets (candy, cookies, cake, ice cream, etc.)

Caffeinated beverages?

When you drink caffeine do you feel irritable or become overactive?

Sleep pattern

Explain:

Reactions to foods

Do you have sensitivities to certain foods?

If yes, list food and symptoms

Do you have an aversion to certain foods? If yes, list food

Do you adversely react to: *(Check all that apply)*

Monosodium glutamate (MSG)
Artificial sweeteners
Garlic/onion
Cheese/milk
Citrus foods
Chocolate
Sulphite–containing foods (wine, dried fruit, salad bars)
Preservatives
Food colourings
Other food substances

Check the factors that apply to your current lifestyle and eating habits:

Are there any foods that you crave
Do you eat 3 meals a day
Do you dislike healthy foods
Are healthy foods readily available
Do you love to eat
Do you have eating issues
Are you an emotional eater (eat when sad, lonely, bored, etc.)

Environmental toxin exposure

Do any of these significantly affect you:

Cigarette smoke
Perfume/colognes
Auto exhaust fumes
Other

In your work or school environment are you regularly exposed to:

Mould
Water leaks
Renovations
Chemicals

Electromagnetic radiation
Damp environments
Carpets or rugs
Old paint
Stagnant or stuffy air Smokers
Pesticides
Herbicides
Harsh chemicals (solvents, glues, gas, acids, etc)
Cleaning chemicals
Heavy metals (lead, mercury, etc.)
Paints
Airplane travel
Other

Have you had a significant exposure to any harmful chemicals:

Chemical name
Length of exposure
Date of exposure

Do you have any pets: Do you have farm animals:

Do the pets live Inside Outside Both inside and outside

Medications taken

1.
2.
3.
4.

Supplements

1.
2.
3.
4.

Medical Symptom Questionnaire

Attached as a separate document: