Child Intake Form

Date	Referred by
Name	
Date of Birth	
Parent/ guardian name/s	
Address	
Phone	
Email	
Health fund	Membership number
Name and age/s of siblings	
Height	Weight

GP	Suburb
Specialist	Suburb

Please list your main concerns and reasons for this appointment:

1. _____
2. _____
3. _____

Recent pathology/tests/investigations/operations etc:

_____

_____

_____

Current medications, herbal or nutritional supplements

Name	Dose

Please list any health concerns of family members including siblings, parents and grandparents:

Please list any previous medical history:

Please explain your child's general temperament:

General Health

Please check boxes if your child has experienced any symptoms below in the previous 12 months.

- ☐ Bloating
- ☐ Flatulence
- ☐ Reflux
- ☐ Colic
- ☐ Burping
- ☐ Nausea
- ☐ Daily bowel movements
- ☐ Irregular bowel movements
- ☐ Constipation
- ☐ Diarrhoea
- ☐ Fussy eating
- ☐ Stomach aches
- ☐ Poor appetite
- ☐ Difficulty gaining weight
- ☐ Recent weight gain

☐ Food intolerances. Please list: _____

☐ Headaches
☐ Sleeping problems

☐ Night terrors
☐ Bed wetting

☐ Clingy
☐ Difficult to settle

☐ Excessive whinging
☐ Anxiety

☐ Mood swings
☐ Poor concentration / focus

☐ Socially withdrawn
☐ Tantrums

☐ Recurrent colds and flu
☐ Hayfever / sinusitis
☐ Asthma

☐ Slow wound healing
☐ Sneezing, coughing, wheezing
☐ Eczema or skin rashes

☐ Itchy eyes, ears, nose, throat, skin

☐ Waxy ears
☐ Cradle cap

☐ Dry skin

Has your child taken any antibiotics?

☐ No
☐ Yes - When and how many courses?

_____

Did you experience any pregnancy complications?

☐ No
☐ Yes - Please explain

_____

_____

Birth details (please tick appropriate boxes)

☐ Vaginal delivery
☐ Caesarean section
☐ Forceps delivery
☐ Vacuum extraction
☐ Foetal distress
☐ Low birth weight
☐ Premature delivery
☐ Prolonged labour

What was your child's birth weight? _____

Was your child breastfed?

☐ No
☐ Yes

Exclusively? _____How long? _____

Was your child formula fed?

☐ No
☐ Yes. Which Formula? _____

Early development

At what age were solids introduced?

_____

What age was your child toilet trained?

_____

Were milestones achieved on time?

☐ No
☐ Yes

Additional information: _____

_____

_____