Cross Natural Health
Dr. Karen Cross FNP, ND
208-392-8383

Child Intake Form

CHILD'S NAME: _____

D.O.B.: _____ AGE:_____ SEX: Male ☐ Female ☐

Date: _____ Referred by: _____

Who is filling out this form (name and relation)? _____

CONTACTS: (in order of preference)

NAME**:** PHONE**:** _____

_____

WORK:_____

Address

_____ OTHER:_____

_____

_____ EMAIL:_____

Relationship to child _____

Whom does the child live with? _____

What are the child's health concerns, in order of importance?

1. _____

2. _____

3. _____

4. _____

5. _____

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Other health care providers:

1.	2.	3.
_____	_____	_____
_____	_____	_____
_____	_____	_____
P:	P:	P:
(_____)_____	(_____)_____	(_____)_____

MEDICAL HISTORY

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

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates:

_____
_____
_____
_____

Which of the following has your child had? (**n** = never **m** = mild **a** = average **s** = severe)

n m a s rubella (german measles)	**n m a s** roseola	**n m a s** impetigo
n m a s measles	**n m a s** scarlet fever	**n m a s** mononucleosis
n m a s chicken pox	**n m a s** whooping cough	**n m a s** ear infections
n m a s mumps	**n m a s** strepthroat	

Does your child have any allergies (medicines, environmental, etc.)?

_____
_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

_____
_____
_____
_____

Please list past prescription medications;

_____
_____

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_____
_____

How many times has your child been treated with antibiotics? _____

Please indicate what immunizations your child has had;

□ DPT (diphtheria, pertussis tetanus) □ Haemophilus influenza B □ Hepatitis B
□ Polio □ "Flu" □ Hepatitis A
□ MMR (measles, mumps, rubella)
□ Tetanus Booster When? _____

Other _____

Please indicate if any caused adverse reactions

_____
_____

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

_____
_____

PRENATAL HEALTH

1. What was the health of the parents at conception?
   Mother: □ Poor □ Fair □ Good □ Excellent □ Unknown
   Father: □ Poor □ Fair □ Good □ Excellent □ Unknown
2. What was the health of the mother during the pregnancy?
   □ Poor □ Fair □ Good □ Excellent □ Unknown
3. What was the mother's age at child's birth? _____
4. How was the mother's diet during pregnancy?
   □ Poor □ Fair □ Good □ Excellent □ Unknown
5. Did the mother receive prenatal medical care? □ Y □ N □ Unknown

6. Did the mother experience any of the following during the pregnancy:

□ Bleeding □ High blood pressure □ Nausea □ Vomiting
□ Diabetes □ Thyroid problems □ Physical or emotional trauma

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Other

_____

_____

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

□ Tobacco □ Alcohol □ Recreational drugs: _____

□ Prescription medications:_____

□ Over-the-counter medications: _____

□ Supplements: _____

□ Other: _____

BIRTH HISTORY

Term length: □ Full □ Premature: _____ wks □ Late: _____ wks

Length of labour: _____ Weight at birth _____

Any complications?

_____

Was the birth: □ Vaginal □ C-section □ Induced □ Forceps □ Anaesthesia used

Did the child experience any of the following at or shortly after birth?

□ Jaundice □ Rashes □ Seizures □ Birth Injuries: _____

□ Birth defects _____

□ Other _____

DIET

How was your infant fed? □ Breast fed and how long? _____ □ Formula Milk/Soy/Other: _____

□ Other: _____

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

_____

_____

6–12 months?

_____

_____

Did your child ever experience colic? □ Y □ N How severe? □ mild □ moderate □ severe

Does your child have any food allergies or intolerances? Please list.

_____

_____

_____

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

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_____

_____

_____

Describe a typical day's diet;
Breakfast

_____

Lunch

_____

Dinner

_____

Snacks

_____

Beverages (and total quantity)

_____

HEALTH AND DEVELOPMENT

How was your child's health in the first year? ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Unknown
At what age did your child first;
Sit up _____ Crawl _____ Walk _____ Talk _____

Describe your child's sleep pattern

_____

_____

How would you describe your child's temperament? _____

_____

How would you describe your child's behaviour at school? _____

_____

FAMILY HISTORY

Indicate if a close relative (parent, sibling) has had any of the following and list who:
☐ Allergies: _____ ☐ Asthma: _____ ☐ Diabetes: _____
☐ Birth Defects: _____ ☐ Kidney Diesease: _____ ☐ Juvenile Arthritis: _____
☐ Other: _____ ☐ I don't know the family medical history

Do either of the parents have a chronic illness? ☐ Y ☐ N Please describe:_____

_____

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ENVIRONMENT

Is the child in school, daycare, home care, or other?_____

What are your child's favorite activities? _____

_____

Does the child exercise regularly? ☐ Y ☐ N How much, how often? _____

_____

How much television does your child watch? _____hours a ☐ day ☐ week

How often does your child read (not for school), or how often does someone read to your child?
☐ Daily ☐ Several times a week ☐ Weekly ☐ Less than weekly

Does anyone in the child's household smoke? ☐ Y ☐ N

Are there animals in the home? ☐ Y ☐ N

How is the child's home heated? _____

Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)?
Please describe:_____

_____

_____

How would you describe the emotional climate of the child's home? _____

_____

Is there anything that you feel is important that has not been covered? _____

_____

_____

THANK YOU FOR TAKING THE TIME TO FILL THIS FORM OUT

IF you are interested in a tailor-made Bach Flower Remedy for your child please fill out the Bach Flower Questionnaire as well. Bach Flowers are totally safe with zero side effects and work on healing emotional and behaviour issues.