VITAL FORCE
Naturopathy

Patient's Name (first, middle, last): ____

Preferred Name: ____

Patient's Date of Birth (Month, Day, Year): _______________________________________

Patient's Age Today: ____

Street Address: ____

City, State, zip: ____

Mother's first/last name and age: ____

Mother's occupation: ____

Mother's phone #: ____

Mother's email: ____

Father's first/last name and age: ____

Father's occupation: ____

Father's phone #: ____

Father's email: ____

812-716-HEAL (4325)
The Horizon Business Center ~ 3012 Eastpoint Pkwy ~ Louisville, KY 40223
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Please use the back side of this intake for answers that won’t fit in the given space.

Who lives in the house with the child (humans and animals please)?

____

____

____

Please describe anything out of the ordinary during the pregnancy.

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Labor duration: ________ ; Induced? YES / NO ; Forceps? YES / NO ; C-Section? YES / NO

Please describe the length and character of your breast feeding effort.

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If there was formula supplementation, at what age did it begin and what brands were used?

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Describe any symptoms of colic or milk intolerance during breast feeding or supplementation?

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When was food introduced? ____

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What is the date or age that you suspected developmental delays?

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Does your child speak? YES / NO

If not, please describe any sounds your child makes and the circumstances vocalized.

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Did your child's lose spoken words? If so, please describe the speech regression.

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What was the frequency and age of first ear infection(s)? _______________________________

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If your child lost social or motor skills, please describe. ________________________________

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Do you associate the decline in your child's functions following a vaccine? If so, which one(s)?

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Please describe any allergies or asthmatic symptoms. __________________________________

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Please list any major food cravings. ____

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Please list all foods commonly consumed: ____

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Is the child potty trained? YES / NO If so, at what age? _______________

Please describe the child's bowel movements. ________________________________

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Does the child have auditory defensive behaviors (extreme sensitivity to sound)? YES / NO

Please describe what types of touch bothers your child? __________________________

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Please describe the daily living activities you must help your child with (dressing, feeding, etc.).

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What aspects of daily living are most troubling to you? ________________________________

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Please describe your child's sleep patterns from birth to now in simple terms. ______________

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Please list all therapies your child has received. ______________________________________

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Please list the current therapies your child is receiving. _________________________________

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Please describe your child’s school programs and grade level. ___________________________

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Does your child have any allergies to medications or supplements? YES / NO

If yes, please list the medication or supplements and the reaction. _________________________

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Please list all medications currently being used (include name and dosing).

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Please list any medications that have failed to help or caused negative reactions.

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Please list all nutritional and herbal supplements being used (include name and dosing).

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Please list the nutritional and/or herbal supplements that you think have helped your child.

What has benefited your child most? ____

Please list any accidents or trauma. ____

Does your child display PICA eating behaviors? YES / NO

Does your child mouth toys or other objects? YES / NO

Please list any surgical history for your child (all procedures and dates).

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Does you child have any other medical concerns? Please circle or add those that are appropriate.

Heart   Chest   Sinuses   Skin   Abdomen/Digestion

Bones/Joints   Neurological/Seizures   Vision   Walking/Running   Genetic

Others: ____

____

____

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Please list all diagnostic tests performed on your child (chromosomal, MRI, EEG, etc.).

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What are your goals for your child's medical care (list most to least important).

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What else would you like us to know about your child or family? _________________________

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Please list any history of maternal thyroid disease or auto immunity? ______________________

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This section to be filled out by the mother.

During your pregnancy, did you have any:

High Blood Pressure	YES	NO	Don't know
Sugar Problems	YES	NO	Don't know
Excessive weight gain (greater than 35 pounds)	YES	NO	Don't know
Marked water retention	YES	NO	Don't know
Pre-ecclampsia or Toxemia	YES	NO	Don't know
Premature Labor	YES	NO	Don't know
Bleeding problems	YES	NO	Don't know

Before and after your pregnancy, did you have any:

Heavy menses with blood clots	YES	NO	Don't know
Migraine headaches	YES	NO	Don't know
High blood pressure	YES	NO	Don't know
Chronic Fatigue	YES	NO	Don't know
Depression	YES	NO	Don't know
Chronically sore or painful muscles or joints	YES	NO	Don't know
Inflammatory bowel disease	YES	NO	Don't know

Chronic or common abdominal pain	YES	NO	Don't know
Chronic headaches	YES	NO	Don't know
Obsessive or compulsive problems	YES	NO	Don't know
Infertility problems	YES	NO	Don't know

Do your relatives have any history of:

Problem pregnancies or getting pregnant	YES	NO	Don't know
Early heart disease	YES	NO	Don't know
Heart attacks	YES	NO	Don't know
Strokes	YES	NO	Don't know
Cancers	YES	NO	Don't know
Migraines	YES	NO	Don't know
Inflammatory bowel disease	YES	NO	Don't know
Autoimmune problems	YES	NO	Don't know
Diabetes	YES	NO	Don't know
Cerebral palsy	YES	NO	Don't know

This section is to be filled out by the father.

Do you have any history of:

High blood pressure	YES	NO	Don't know
Heart disease	YES	NO	Don't know
Strokes	YES	NO	Don't know
Migraines	YES	NO	Don't know
Abdominal pain	YES	NO	Don't know

Muscle pain all the time	YES	NO	Don't know
Persistent joint pain	YES	NO	Don't know
Autoimmune disorders	YES	NO	Don't know

Do your relatives have any history any of:

High blood pressure	YES	NO	Don't know
Heart disease	YES	NO	Don't know
Strokes	YES	NO	Don't know
Migraines	YES	NO	Don't know
Abdominal pain	YES	NO	Don't know
Muscle pain all the time	YES	NO	Don't know
Persistent joint pain	YES	NO	Don't know
Autoimmune disorders	YES	NO	Don't know
Problem pregnancies	YES	NO	Don't know
Infertility problems	YES	NO	Don't know
Heart attacks	YES	NO	Don't know
Strokes	YES	NO	Don't know
Cancers	YES	NO	Don't know
Inflammatory bowel disease	YES	NO	Don't know
Diabetes	YES	NO	Don't know
Cerebral palsy	YES	NO	Don't know