Health Intake Questionnaire – Child

Child full name: Date of birth:

Parent name: Weight:

Full Address: Phone number:

Reason for reaching out:

1. Briefly describe what prompted you to contact me.

Please share your child's health background:

2. All past and present medical conditions/diagnoses/surgeries.

3. Describe any emotional or physical challenges experienced during pregnancy and throughout your child's first year of life.

4. List any medications your child has taken (include past and current).

5. List all vitamins, minerals, and other nutritional supplements your child is currently taking.

6. Is your child currently seeing other health or wellness professionals (ie., chiropractor, osteopath, occupational therapist, naturopath, etc.)? If yes, please list the main focus of their care.

7. How many bowel movements does your child have per day?

Constipation (straining, less than 1 bowel movement/day):	Yes	No
Diarrhea (loose stool, sticky stool):	Yes	No

8. Has your child exhibited any of the following:
    - Language and/or communication delay
    - Stuttering
    - Social withdrawal/clinginess
    - Repetitive/odd behaviours (flapping, ticks, OCD tendencies, toe walking, rocking)
    - Difficulty with transitions or changes in routine
    - Gross motor delay (crawling, walking)
    - Balance issues
    - Toileting difficulties
    - Snoring
    - Grinding teeth
    - Cavities
    - Mouth breathing
    - Frequent ear infections
    - Sensory sensitivities (sounds, textures, lights)
    - Emotional regulation challenges (meltdowns, anxiety, difficulty calming)
    - Other:

9. Describe any concerns you have with your child's diet (ie., not enough hydration/vegetables, frequent tummy aches, picky eater, poor food choices, etc.).

10. On average, how many hours does your child sleep per night?

    If your child has night wakings, what time is it typically?

INTEGRATIVE HEALTH PRACTITIONER All information provided is for health education purposes only and is not intended to diagnose, treat, cure, or prevent any disease.

11. Did your child experience any major life changes or stressors around the time your concerns began (ie., new sibling, new schedule, a loss, etc.)?

    Yes No

    Is the stressor(s) ongoing?

    Yes No

12. List any current practices for mindfulness/nervous system regulation practiced at home (ie., breathing, gratitude, prayer, yoga, etc.)

13. Does your child have calming strategies during high stress incidents (ie., deep pressure, deep breaths, cuddles, quiet space, movement)?

14. Do you, as a parent, follow any calming strategies for yourself? If yes, please describe.

15. Check everything you currently do to decrease your family's toxic load at home:

    - Healthier alternatives to foods (organic, non-GMO, grass fed, pasture raised meats, etc.)
    - Cook using non-toxic cookware and oils
    - Avoid certain ingredients by reading labels
    - Mainly home cooked foods
    - Natural cleaning products
    - Holistic oral care
    - Air purifier
    - Reverse Osmosis water filter with trace minerals
    - EMF protection
    - Detox baths
    - Lymph massages
    - Other/notes regarding above:

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16. Check how interested you are in making changes to decrease your child' s toxic load.

- I'm not interested at all
- I'm only interested to learn about smaller simple swaps
- I'm only interested in swaps that address the highest toxic impact on my child's health
- I'm interested to learn as many swaps as I can possibly make

Disclaimer

I understand that an Integrative Health Practitioner is not authorized under any circumstances, to diagnose, treat, or prescribe for any medical condition or disease under Ontario law or any applicable Canadian legislation. I understand that this providers' advice as an Integrative Health Practitioner is based on general health and wellness principles and does not address specific medical conditions. An Integrative Health Practitioner provides non-medical, advisory services, including but not limited to dietary recommendations, supplement advice, and lifestyle/emotional guidance. These services are not intended to replace or substitute professional medical care, diagnosis, or treatment by a licensed healthcare provider. It is recommended to consult with your physician or healthcare professional regarding specific health matters.

I understand that bioresonance evaluation does not provide a medical diagnosis and that further medical care and testing may be recommended. If I suspect I need medical intervention I understand I should consult my physician. I give my permission to be evaluated with a bioresonance scan. I understand in doing so, my testing technician is not my primary physician. I understand that I will receive information about my body's energetic field and recommendations based on said evaluation.

I understand and acknowledge that all advice and recommendations provided are entirely voluntary and non-binding. I have the sole discretion to accept, modify, or reject any suggestions. I understand that recommendations are for informational purposes only and are not a guarantee of results.

Parent/guardian signature: Date: