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Pediatric Intake Form

Personal Information:

Child's name: ____

Date of Birth_____/_____/_____ Today's Date: _____/_____/_____

Gender: ____________________ Age: ______________________

Address: ____

Province: ________ City: ________________ Postal Code: ______________

Home phone number: Home: (____) ____ - ____

Parents/ Guardians (in order of preference) Phone

Name: ____________________________________ (H) ______________________________

Address____________________________________ (W) ______________________________

____ (Cell) ____________________________

Relationship to child __________________________ Email ____________________________

Name: ____________________________________ (H) ______________________________

Address____________________________________ (W) ______________________________

____ (Cell) ____________________________

Relationship to child __________________________ Email ____________________________

May we leave you phone messages/call to confirm and cancel appointments? Yes☐ No☐

Which Phone Number: ____________________

Who is filling out this form (Name and Relation)? ______________________________________

With whom does the child with? ____

How did you hear about the clinic? ____

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Emergency Contact:

Name: ____ Relationship:____________________________

Phone Number: (____) ____ - ____

Other Health Care Providers:

Name of Primary Care doctor: ___________________________________ Phone: (____) ____ - ____

Name of Pediatrician: ____ Phone: (____) ____ - ____

Name of specialists/doctors: _____________________________________ Phone: (____) ____ - ____

Has your child been to see the dentist? ☐Yes ☐No

Describe any dental work done: ____

____

Describe your child's daily oral hygiene practice: __________________________________

____

Medical History:

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

Please list you HEALTH CONCERNS/GOALS by the order of importance:

Concern/Goal	**Since**
1.	
2.	
3.	
4.	
5.	

Please indicate any TRAUMATIC EVENT (surgery, trauma), illnesses, injuries and hospitalization along with approximate dates:

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Traumatic event	Date
1.	
2.	
3.	

Medications, Supplements and Allergies:

Please list all your current MEDICATIONS/SUPPLEMENTS: (prescription, over the counter, Vitamins, minerals, herbs, homeopathics, etc

Item	Dose	Frequency	Taken For	Date Started

Please list all past PRESCRIPTION MEDICATIONS:

Item	Dose	Frequency	Taken For	Date Stopped

How many courses of antibiotics has your child taken: ____

Please list any ALLERGIES or MEDIC ALERT warnings (food, drugs, herbs, environmental):

1.	Reaction:
2.	Reaction:
3.	Reaction:
4	Reaction:
5.	Reaction:

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Past Medical History:

Please check the following conditions you have had:

	Yes	**Past**	**Comments**
ADD/ADHD			
Allergies			
Anxiety			
Asthma			
Atopic Dermatitis			
Bed Wetting			
Chicken Pox			
Chronic bleeding Noses			
Chronic Bruising			
Chronic Colds			
Cold Sores			
Colic			How Severe:
Conjunctivitis (Pink Eye)			
Constipation			
Cough & Wheezing			
Cradle Cap			
Cystitis			
Diaper Rash			
Diarrhea			
Difficulty Concentrating			
Difficulty Sleeping			
Digestive Problems			
Ear Infection			
Hay fever			
Headaches			
Head Lice			
Impetigo			
Influenza			
Measles			
Mononucleosis			

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Mumps			
Pneumonia			
Roseola			
Recurrent Fevers			
Rubella (German Measles)			
Scarlet Fever			
Seizures			
Sinus Problems			
Skin conditions (Eczema, etc)			
Strep Throat			
Thrush			
Whooping Cough			
Other			

Immunization:

Please indicate what immunizations your child has had: (Y: Yes, N: Never)

Vaccination			**Adverse Reaction**
DTaP [Diphtheria, Tetanus, Pertusis (Whooping Cough)]	Y	N	
IPV [Polio]	Y	N	
Hib [Haemopilus Influenza Type B]	Y	N	
Pneu-C-13 [Pneumococcal Disease]	Y	N	
Rot [Rota Virus]	Y	N	
Influenza [The Flu]	Y	N	
Men C [Meningococcal Disease]	Y	N	
MMR [Measles, mumps, Rubella]	Y	N	
Varicella [Chicken Pox]	Y	N	
Hepatitis B	Y	N	
Hepatitis A	Y	N	
Small Pox	Y	N	
Tetanus Booster	Y	N	When:

What Screening Tests has your child had? (Blood, Hearing, Vision, etc.)

Test	**When**

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Family History:

	Mother	**Father**	**Gr. Parents**	**Siblings**	**Children**
Allergy					
Asthma					
Birth Defects					
Cancer					
Depression					
Diabetes					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Juvenile Arthritis					
Kidney Disease					
Thyroid Illness					
Substance Abuse (Drug, Alcohol)					
Any Known Genetic disease					
Other Chronic Conditions					

☐ I don't know my family history

Prenatal History:

What was the health of Parents at Conception?

Mother ☐Poor ☐Fair ☐Good ☐Excellent ☐Unknown

Father ☐Poor ☐Fair ☐Good ☐Excellent ☐Unknown

Mother's Health:

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What was the health of the mother during the pregnancy?

☐Poor ☐Fair ☐Good ☐Excellent ☐Unknown

What was the mother's age at child's birth? ____

Did mother receive prenatal medical care? ☐Yes ☐No

How was mother's diet during pregnancy? ☐Poor ☐Fair ☐Good ☐Excellent ☐Unknown

Did mother experience any of the following during the pregnancy?

☐Diabetes ☐High Blood Pressure
☐Bleeding/Hemorrhage ☐Thyroid Problem
☐Nausea ☐Vomiting
☐Physical or Emotional Trauma
☐Other Complications during Pregnancy, Labor or Delivery:______________________________

____

____

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

☐Tobacco ☐Alcohol ☐Recreational Drugs If Yes, How Much? ________________________

When? ________________________

☐Prescription Medication If Yes, what Type & How Much? ________________________

☐Over the Counter Medications If Yes, what Type & How Much? ________________________

☐Supplements If Yes, what Type & How Much? ________________________

____

☐Exposed to Second Hand Smoke

☐ Other: ____

Birth History:

Name of Midwife/Obstetrician: ____

Location of Birth: ____

Length of Term: ☐ Full ☐ Premature Weeks: ____ ☐Late Weeks: ____

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Length of Labour: ____

Weight at Birth: _________________________ Length at Birth: ____________________

Was the birth: ☐Vaginal ☐C-section ☐Induced ☐Forceps

Any Complications: ____

Medications taken during Labour/delivery: _______________________________________

Did your child experience any of the following at or shortly after Birth?
☐ Jaundice ☐ Rashes ☐ Seizures
Birth Injuries:____

Birth Defects: ____

Other: ____

<u>Feeding History & Current Diet:</u>

Was your child breast fed? ☐Yes ☐No How many months: ______________________________

Was your child formula fed? ☐Yes ☐No how long: ______________________________________

Type (Milk, Soy, Other): __________________________

At what age was solid foods first introduced? ____

What foods were introduced before 6 months? (please list the approximate dates)

____

____

____

____

____

What foods were introduced 6-12 months? (please list the approximate dates)

____

____

____

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____

____

Food Preferences: ____

____

____

Any Food Allergies and Intolerances: _______________________________________

____

____

Any Dietary Restrictions (Religious, Vegetarian, Vegan, etc)? __________________

____

____

Dietary Intake:

Please List a Typical day's diet including beverages:

Breakfast: ____

Lunch: ____

Dinner: ____

Snack: ____

Beverages: ____

What is the approximate weight of your child? _______________

Any recent weight gain or weight loss? ☐ Yes ☐ No How much: ___________________

Sleep Habits:

What are your child's current sleep habits? _______________________________________

____

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What time does your child go to bed? ____

Does your child take naps? ☐ Yes ☐ No When: ____________________________________

Does your child fall asleep easily? ☐Yes ☐No

Does your child wake up looking/acting refreshed? ☐Yes ☐No

Please list recurrent dreams and/or nightmares: ____________________________________
____

Does you child experience any bedwetting? If yes, for how long? _______________________
____
____

Development:

How was your child's health in the first year? ☐Poor ☐Fair ☐Good ☐Excellent ☐Unknown

At what age did you child first:

Crawl: ______________________ Sit up: ______________________
Walk: ______________________ Talk: ______________________

How would you describe your child's behavior and performance at school? (Please list any Learning disabilities or concerns with school performance)
____
____
____
____

Does this differ greatly from behavior at home? ___________________________
____
____

What makes your child angry? ____
Does your child have any difficulties expressing anger? _________________________________

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____

How does your child react when afraid? ____

____

Social/psychosocial:

Is the child in: ☐School ☐Daycare ☐Homecare Other: ______________________________

Does your child enjoy playing with other children? ☐Yes ☐No

What extracurricular activities is your child involved in? _________________________________

____

____

List your child favorite activities: ____

____

____

Does your child exercise regularly? ☐Yes ☐No How much, How often, What type? __________

____

____

How much television does your child watch? ________ Hours a ☐day _______ Hours a ☐week

Are there pets in the home? ☐Yes ☐No

How often does your child read for fun?

☐daily ☐several times a week ☐weekly ☐Less than weekly

How often does someone read to your child?

☐daily ☐several times a week ☐weekly ☐Less than weekly

Describe level of stress & emotional climate of your home: ______________________________

____

____

What does your family do together for fun? ____

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____

Do you know of any toxins or other hazards the child is regularly exposed to? ____________________

____

____

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

____

____

I affirm that I have stated all my child's known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my child's medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

Signature __________________________________ Date ______________________________

Thank you for taking the time to fill out this extensive health intake form.
All the above information is important in developing the best treatment plan for your child.