PEDIATRIC INTAKE FORM (BIRTH TO 10 YEARS)

Patient's Name: ____ Date: __________________

Age: _________ Date of Birth: (M/D/Y)______________________ Gender: Female / Male

Parent/Guardian's Name: ____

Address:____

City: ______________________________________ Prov: ________________ Postal Code: ______

Telephone (home): ___________________ (Parent's work): ______________________________

How did you hear about this clinic? ____

If internet: Google:____ CAND Website:____ OAND Website:____ Other:_________________________

Has any other family member already been a patient at this clinic? ________________________________

____

Name of doctor's office/hospital/clinic where your child's health records are kept: ___________________

____

What are your child's health concerns:____

____

____

____

MEDICATIONS

NOW	PAST		NOW	PAST	
____	____	Aspirin	____	____	Decongestants
____	____	Tylenol	____	____	Anti-histamine
____	____	Antibiotics	____	____	Ibuprofen

Other current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.):

____

____

____

____

Other past prescription medications

____

____

Allergies to medicines: __________________________________

MEDICAL HISTORY

____ Chicken pox ____ Scarlet fever ____ Tonsillitis, approx no. of times: __________

____ Measles ____ Pneumonia ____ Ear infections, approx no. of times: ______

____ Mumps ____ Frequent colds ____ Strep throat, approx no. of times: ________

____ Rubella ____ Rheumatic fever ____ Other: ____________________________

Has your child ever had any of the following? WHEN WHERE RESULTS?

Electroencephalogram (EEG): ____

Psychological evaluations: ____

Hearing test: ____

Speech/language tests: ____

Injuries/surgeries/hospitalizations (please list): _________________________________

____

____

IMMUNIZATIONS

____ MMR ____ DPT ____ Chicken pox Others:_________________________

____ Measles ____ Diphtheria ____ Small pox Adverse reactions: Y / N

____ Mumps ____ Tetanus ____ H. influenza If so, what? ______________________

____ Rubella ____ Polio ____ The flu ____________________________

PLEASE FILL OUT BOTH SIDES OF FAMILY HISTORY

FAMILY HISTORY

____ Heart disease ____ Diabetes ____ Birth defects

____ Hypertension ____ Arthritis ____ Tuberculosis

____ Cancer ____ Allergies ____ Asthma

____ Mental illness ____ Osteoporosis ____ Other significant:_____________

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications?

____

____

Mother's age at child's birth: ______

Mother's health during pregnancy:

____ Bleeding	____ Nausea	____ Physical or emotional trauma
____ Illnesses	____ Hypertension	____ Cigarettes, alcohol, drug consumption
____ Medications	____ Diabetes	____ Thyroid problems

BIRTH HISTORY

Term: ____ Full ____ Premature ____ Late Weight at birth: _________________________

Length of labor: ___________________ Complications: ______________________________

Did your child have any of the following problems shortly after birth?

____ Rashes	____ Birth injuries	____ Blue baby
____ Jaundice	____ Seizures	____ Cerebral palsy
____ Colic	____ Fever	____ Birth defects

____ Other: ____

Child's sleep patterns (1st year): ____

Current Sleep patterns ____

Food intolerances: ____

Breast fed: Y / N How long: ___________ Formula: Y / N Type (milk, soy):____________

Age began solids: _________ Which foods: ____

Age began (approximately): Sitting _______ Crawling _______ Walking _______ Talking ________

How would you describe your child's temperament?

____

____

How would you describe your child's behavior and performance at school?

____

____

SYMPTOMS (check if your child has any of the following)

____ Hives	____ Burning urine	____ Bloody urine	____ Eczema
____ Cries easily	____ Bleeding gums	____ Heart murmur	____ Nervous
____ Nose bleeds	____ Vomiting spells	____ Sleep problems	____ Asthma
____ Acne	____ Anemia	____ Night sweats	____ High fevers
____ Jaundice	____ Sensitive to light	____ Chronic rash	____ Stomach aches
____ Diarrhea	____ Hearing loss	____ Easy bruising	____ Sore throats
____ Flat feet	____ No appetite	____ Body/breath odor	____ Constipation
____ Nightmares	____ Frequent colds	____ Bleeding tendency	____ Unusual fears
____ Wheezing	____ Joint pains	____ Excessive fatigue	____ Cough
____ Dizzy spells	____ Hair loss	____ Frequent urination	____ Allergies

DIET

Please describe your child's typical daily diet:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

To drink: ____

Environment

Is the child in: ☐ school ☐ daycare ☐ home care ☐ other

What are your child's favourite activities?

____

____

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

How much television does your child watch?_____________hrs 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. WE LOOK FORWARD TO HELPING YOUR CHILD IN ANY WAY WE CAN.