Pediatric Intake Form

CONTACT INFORMATION:

Patient name: ______________________________ DOB (d/m/y)__________ Age:____ Sex: Male Female

Name of parent/guardian:____ Relationship: ________________

Address: _________________________________ City: ________________ Prov: ____ Postal:___________

Home telephone: __________________________ Work:_______________ Mobile: ____________________

Alternate contact:__________________________ Relation: ____________ Telephone:_________________

Guardian email: ____

OTHER HEALTH CARE PROVIDERS:

1. Family physician: ________________________ Telephone: _______________________ Fax:_____________

   Address: _______________________________ City: _______________ Prov: ____ Postal:___________

2. Other health provider: _____________________ Profession:___________ Phone:_____________________

3. Other health provider: _____________________ Profession:___________ Phone:_____________________

MEDICAL HISTORY:

Your child's current health and well-being are: Excellent Very Good Good Fair Not good Poor

Health concerns (please list in order of importance):

1. ____ Date of onset:_______________
2. ____ Date of onset:_______________
3. ____ Date of onset:_______________
4. ____ Date of onset:_______________

Please list any injuries, severe illnesses or traumatic events (in order of importance):

1. ____ Date of event:_______________
2. ____ Date of event:_______________
3. ____ Date of event:_______________
4. ____ Date of onset:_______________

Has your child experienced any of the following?

- ☐ Rubella (German measles)
- ☐ Rubeola (English measles)
- ☐ Chicken pox
- ☐ Mumps
- ☐ Roseola
- ☐ Scarlet fever
- ☐ Whooping cough
- ☐ Strep throat
- ☐ Impetigo
- ☐ Mononucleosis
- ☐ Ear infections

Please indicate the immunizations your child has received:

- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ Tetanus booster
- ☐ Polio
- ☐ MMR (measles, mumps, rubella)
- ☐ Haemophilus influenza B
- ☐ "flu"
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Other ________________________________
  ____

Please list, if any symptoms following immunizations: ____

____

Please list all medications/supplements being taken by your child:

____

____

How many courses of antibiotics has your child been treated with? __________

Please list any surgeries or procedures that you child has undergone:

1. ____ Date of event:_______________
2. ____ Date of event:_______________
3. ____ Date of event:_______________

Has your child had any of the following? If so, what was the reason and when was the most recent date?

- ☐ Blood work for: ______________________________________ Date: _______________
- ☐ X-rays or imaging for: ______________________________________ Date: _______________
- ☐ Eye Examination for: ______________________________________ Date: _______________
- ☐ Hearing tests for: ______________________________________ Date: _______________

FAMILY HISTORY

CONDITION	FAMILY MEMBER(S)	CONDITION	FAMILY MEMBER (S)
Allergies		Depression	
Asthma		Other mental health issues	
Heart disease		Thyroid disorder	
Cancer		Kidney disease	
Diabetes		Other_________________	

PRENATAL HEALTH

Please rate each parent's health at conception:

Mother: Excellent Very good Good Fair Not good Poor Unknown

Father: Excellent Very good Good Fair Not good Poor Unknown

Please rate the health of the mother during pregnancy

Excellent Very good Good Fair Not good Poor Unknown

Mother's age at child's birth: ___________ Did the mother receive prenatal care? ☐ Yes ☐ No

Did the mother experience any of the following during pregnancy?

☐ Bleeding
☐ Diabetes
☐ Thyroid issues
☐ Severe nausea or vomiting
☐ Physical or emotional trauma
☐ High Blood pressure
☐ Other: ____

Were any of the following used during pregnancy?

☐ Tobacco
☐ Alcohol
☐ Recreational drugs, please specify:____
☐ Prescription medications, please specify: ____
☐ Over the counter medications, please specify: ____
☐ Supplements, please specify: ____
☐ Other, please specify: ____

BIRTH HISTORY

Length of pregnancy term: ☐ Full Term ☐ Premature ________wks ☐ Late __________wks

Length of labour: __________hrs Weight at birth __________

Please indicate if the birth was: ☐ Vaginally delivered ☐ Delivered by C-section ☐ Induced

Please indicate if any of the following was required: ☐ Epidural or anesthesia ☐ Forceps

Were there any complications following birth? ____

Did your child experience any of the following shortly after birth?

☐ Jaundice ☐ Rashes ☐ Seizures ☐ Birth injuries ☐ Birth defects ☐ Other: _____________

INFANCY

Was your child ☐ Breast fed? If so, for how long? ______ ☐ Formula fed (milk/soy/other: __________)

Please list the foods that were introduced in sequential order and at what age they were introduced:

1. ______________________ Age: ______
2. ______________________ Age: ______
3. ______________________ Age: ______
4. ______________________ Age: ______

At what age was your child able to: Sit up _____ Crawl _____ Stand _____ Walk _____ Talk _____

DIET

Please list any known food allergies or sensitivities:

____

____

Favorite foods:

____

____

Dietary restrictions:

____

____

SLEEP

Please indicate if your child experience's any of the following sleep habits/behaviours/ issues:

☐ Frequent nightmares ☐ Sleep walking ☐ Teeth grinding ☐ Bed wetting ☐ Other __________

DEVELOPMENT

Please list any concerns about your child's mental or physical development:

____

____

SOCIAL/PSYCHOLOGICAL

Does your child currently attend daycare or school? ____

Please list any learning disabilities or concerns with school performance:

____

____

How would you describe your child's personality?

____

____

Does your child enjoy playing with other children? ____

How much time each week is spent with friends and peers? _____________

What are their activity preferences? How do they like to spend their time?

____

____

What extracurricular activities is your child involved in?

____

____

How much time is spent each day watching television and playing video games? ___________

Is your child involved in any form of exercise? If so, what type of exercise and how often?

____

____

HOME & FAMILY

Parent's occupations ______________________________________ Does anyone at home smoke? ____

Describe the home environment

____

____

What does your family do together for fun?

____

____