

## Pediatric Intake Form

### General Information

Child's Name: \_\_\_\_\_ Birth Date \_\_\_\_\_ Gender \_\_\_\_\_

Address \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Address (if different from child): \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ May leave message?  Y  N

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

Would you like to receive our newsletter? Email Address \_\_\_\_\_

### Primary Health Concerns

Please list health concerns order of importance to you:

CONCERN	WHEN DID IT FIRST OCCUR	WHAT MAKES BETTER	WHAT MAKES WORSE

Past/Present Medications (include supplements, antibiotics, vitamins, homeopathics)

NAME	DURATION

### Illnesses (Past and Present)

Mumps	Ear infections	Influenza	
Measles	Frequent colds	Small pox	
Rubella	Tonsillitis	Tetanus	
Allergies	Scarlet fever	Diphtheria	
Pneumonia	Rheumatic fever	Hepatitis	
High fevers	Pertussis		
Chicken pox	Other:		

Past Medical History (surgeries, injuries, hospitalizations)

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Symptoms Your Child has Displayed

Stomach aches	Constipation	Eczema	Tendency to bleed
Frequent vomiting	Diarrhea	Headaches	Sore throat
Change in appetite	Easy bruising	Cough	Bed wetting
Body/breath odour	Nosebleeds	Wheezing	Blood in urine
Frequent urination	Hearing loss	Fatigue	Unusual fears
Cries easily	Hair loss	Nervousness	Dizzy spells
Night sweats			

Suspected Allergies and Intolerances

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Immunizations

Measles	Diphtheria	Hepatitis
Mumps	Pertussis	Influenza
Rubella	Tetanus	Small Pox
Polio	Other	

Any adverse reactions to any of the above?

If yes, explain:

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## Birth and Prenatal History

Term of pregnancy: \_\_\_\_\_ Caesarean section: Y N  
 Birth weight: \_\_\_\_\_ Birth length : \_\_\_\_\_  
 Interventions during birth (i.e. forceps, epidural): \_\_\_\_\_  
 If yes, explain: \_\_\_\_\_

Mother's age at birth: \_\_\_\_\_  
 Mother's health at conception (rate on scale 1 to 10): \_\_\_\_\_  
 Mother's health during pregnancy (rate on scale 1 to 10): \_\_\_\_\_

### Symptoms or interventions during pregnancy:

Nausea	Hypertension	Rhogam Shot (Rh+/-)	
Bleeding	Physical trauma	Other illnesses (specify below)	
Thyroid problems	Diabetes	Emotional stress	
Other Illness (list)			

Medications or drugs used during pregnancy (including alcohol, tobacco, recreational drugs):

\_\_\_\_\_

\_\_\_\_\_

Was infant nursed? \_\_\_\_\_ If yes, how long? \_\_\_\_\_  
 If no, alternative used? \_\_\_\_\_

Food reactions or intolerances (past and present): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Symptoms which occurred at birth or during infancy:

Colic	Rashes	Birth injuries	
Seizures	Jaundice	Birth defects	

### Age the following milestones were achieved:

1 <sup>st</sup> tooth	Sitting	Solid foods	
All teeth	Crawling	Toilet trained	
First words	Walking		

Child's health in the past year (1=poor, 10=excellent): \_\_\_\_\_

Any significant change from the previous year: \_\_\_\_\_

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

Child's activity level (1=poor, 10=excellent): \_\_\_\_\_

Favourite activities or hobbies: \_\_\_\_\_

Child's temperament: \_\_\_\_\_

Behaviour and performance at school: \_\_\_\_\_

Communication with others (children and adults): \_\_\_\_\_

Any pets in home: \_\_\_\_\_

Urban or rural home: \_\_\_\_\_

Type of heating used in home: \_\_\_\_\_

Any smokers in the home: \_\_\_\_\_ If yes, how many? \_\_\_\_\_

How often has child moved? \_\_\_\_\_

Any recent renovations to current or recent homes: \_\_\_\_\_

If yes, specify: \_\_\_\_\_

Has child had direct exposure to any potentially harmful substances or chemicals (pesticides, herbicides, insecticides, household cleaners, lead piping, poisons etc.) Please specify:

What is the current parenting situation at home (both parents at home, joint custody, single parent etc.)?

Outside of school, about how many hours a week does the child spend at the following:

Physical activities (sports, play, etc.): \_\_\_\_\_

Electronic activities (TV, computer, video games): \_\_\_\_\_

Outdoor activities : \_\_\_\_\_

Creative activities (reading, schoolwork, music, etc.): \_\_\_\_\_

## Family Health History

In the following table, please indicate which of the following ailments, have affected your relatives. Please specify any other major ailments not listed here.

Alcoholism	Asthma	Diabetes	Gout	Paralysis	Skin Disease
Allergies	Cancer	Epilepsy	Hay Fever	Pneumonia	Syphilis
Arthritis	Depression	Gonorrhea	Heart Disease		Tuberculosis

RELATIVE	AGE (IF LIVING)	AGE AT DEATH	AILMENTS AND CAUSE OF DEATH
Mother:			
Father:			
Brothers:			
Sisters:			
Children:			
Maternal Grandmother:			
Maternal Grandfather:			
Maternal Aunts/Uncles			
Paternal Grandmother:			
Paternal Grandfather:			
Paternal Aunts/Uncles			

