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Pediatric Intake Form (Ages 0-12)

We are aware of the time it takes to fill out such a lengthy intake form. However, your co-operation in completing it is essential to providing the highest standard of care. All information is confidential. PLEASE PRINT.

REGISTRATION

Today's Date _______________

Child's Name ____
Parent's Name(s) ___________________________________Email __________________________
Age __________ Date of Birth ________________ Gender: Male Female
Place of Birth _____________________ Ethnicity ______________________________

Address ____
____ Phone (____)_________________
Email Address ____________________
Emergency Contact ___________________________ Relation _____________________
Phone (____)_________________How did you find out about our clinic? ✓referral – Whom may we thank? ______________

✓website
✓yellow pages
✓health food store
✓other ______________

Other Health Care Providers

1. _________________ 2. _________________ 3. ________________
____________________ ____________________ ____________________
(____)_______________ (____)______________ (___)_______________

Health Concerns (in order of importance):

1. ____
2. ____
3. ____
4. ____
5. ____

Developmental History

Current Height __________ Current weight ___________
Has your child reached all their developmental milestones?
Yes No Don't Know

MEDICAL HISTORY (please check all that apply to your child):
(   ) Allergies (food, medication, environmental)
(   ) Asthma
(   ) Ear infections
(   ) Frequent colds/sore throats
(   ) Surgery   For what?____________________ When? _______________________
(   ) Hospitalization   For what?_________________ When? _____________________
(   ) Trauma (ie accidents, falls, fractured bones, sprains, etc) Explain
____

Medications (past and current, include supplements):
________________________   ________________________   ________________________
________________________   ________________________   ________________________

Diet
Does your child have any food allergies/intolerances?
____
____
Does your child have any dietary restrictions (religious, vegetarian, vegan)?
____
____

Is your child a “picky” eater? Yes   No Please explain.
____

Typical daily diet:
Breakfast ____
Snack ____
Lunch ____
Snack ____
Dinner ____
Snack ____
Beverages (and total quantity) ____

IMMUNIZATION HISTORY (please indicate those your child has recieved and any reactions):

Vaccination	**Date Received**	**Adverse Reactions** (i.e. fever, rash, joint pain, fatigue, vomitting, seizures)
DPT (diptheria, pertussis and tetanus)		
Tetanus booster, when?		
MMR (measles, mumps, rubela)		
Haemophilus influenza B (HiB)		
“Flu”shot		
Polio		
Hepatitis A		
Hepatitis B		
Smallpox		
Chickenpox (Varivax)		

PRENATAL HISTORY:

Mother's age when child born __________Father's age when child born __________

How was each parent's overall health prior to pregnancy?
Mother ____
Father ____

Were there any complications during the pregnancy (trauma, emotional stress, high blood pressure, diabetes, weight gain, medications taken) ? Please explain.
____

How was the labour and delivery? Were there any interventions (i.e. forceps, vaccuum, Cesarean section)?____

Was your child born - before 38 weeks gestation? Yes No
- after 42 weeks gestation? Yes No

Child's weight at birth _____________ Child's length at birth _______________
How were your child's APGAR scores at birth, if known? ______________________

Was your child breastfed? Yes No
If Yes, for how long? ____
If No, what formula was your child given? _______________________________

Was your child healthy during the neonatal period? Yes No
If No, please explain ____

At what age was solid food introduced? ____

FAMILY HISTORY (Please indicate if a close relative has had any of the following):
( ) Allergies Who? ___________________ ( ) Diabetes Who? ___________________
( ) Asthma Who? ___________________ ( ) Kidney disease Who? ___________________
( ) Cancer Who? ___________________ ( ) Heart disease Who? ___________________
( ) Depression Who? ___________________
( ) Other mental illness Who? ___________________
( ) Drug/Alcohol abuse Who? ___________________
( ) Don't know family medical history

Social History:
Does your child attend daycare or school? Yes No
If Yes, what grade/level are they in? ______________________________________

Does your child enjoy school? Yes No Don't Know
Please explain. ____

How is your child's social and academic performance (both in school and at home)?
____

Does your child have any known learning disabilities? Yes No Don't Know
Has your child had developmental tests? Yes No

Has your child had their vision checked? Yes No Results
____

How does your child interact with their peers or other children?
____

Is your child involved in any extra-curricular activities, sports, hobbies?
Yes   No   Please explain. ____

What does your child enjoy doing on their spare time?
____

How much television does your child watch, including video games?
(   ) Less than 1 hour per day
(   ) 1-4 hours per day
(   ) More than 4 hours per day

How much sleep does your child get per night, on average? __________________

Is your child exposed to any of the following on a regular basis?
(   ) Second hand cigarette smoke
(   ) Marijuana smoke
(   ) Animals, what kind? _____________________
(   ) Stress (emotional, physical)

Please rate the household stress level (0 = no stress, 10 = high stress)
0   1   2   3   4   5   6   7   8   9   10

Please add anything else you think is relevant to your child's medical history?
____
____