

## Pediatric Intake Information

**Child's Name:** \_\_\_\_\_

**Sex:** M / F

**Date of Birth:** \_\_\_\_\_  
(Year/Month/Day)

**Who is filling out this form (name and relation)?** \_\_\_\_\_

**Caretakers and/or Emergency Contacts (please list in the order you would like us to contact in case of an emergency):**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: (H) \_\_\_\_\_

(W) \_\_\_\_\_

(C) \_\_\_\_\_

Email: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: (H) \_\_\_\_\_

(W) \_\_\_\_\_

(C) \_\_\_\_\_

Email: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: (H) \_\_\_\_\_

(W) \_\_\_\_\_

(C) \_\_\_\_\_

Email: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

**May we leave messages relating to your visits? Y / N**

If so, which phone number? \_\_\_\_\_

**With whom does the child live?**

\_\_\_\_\_

\_\_\_\_\_

**Who referred you to the clinic and/or where did you hear about the clinic?**

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**Please list the medical professionals the child currently sees:**

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**What are the child's health concerns, in order of importance:**

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**Please list any serious conditions, illnesses, or surgeries/hospitalizations:**

Condition	Year
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<hr/>	<hr/>
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**Which of the following has the child had? (N = never, M = mild, A = average, S = severe)**

- |                                  |                        |                        |
|----------------------------------|------------------------|------------------------|
| N M A S rubella (german measles) | N M A S roseola        | N M A S impetigo       |
| N M A S measles                  | N M A S scarlet fever  | N M A S mononucleosis  |
| N M A S chicken pox              | N M A S whooping cough | N M A S ear infections |
| N M A S mumps                    | N M A S strep throat   |                        |

**Allergies/Intolerances:**

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(chemical/drug)

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(food)

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(other)

**Number and Age of Siblings:**

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**Please list all current medications (prescriptions, over-the-counter, vitamins, herbs, homeopathics, etc.), including dose:**

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**Please list any past prescription medications:**

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**How many times has the child been treated with antibiotics?**

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**Please indicate what immunizations the child has had:**

- DPT (diphtheria, pertussis, tetanus)
- Tetanus booster; when?
- MMR (measles, mumps, rubella)
- Haemophilus Influenza B
- Flu
- Polio
- Hepatitis A
- Hepatitis B
- Smallpox
- Other \_\_\_\_\_

**Please indicate any adverse reactions:**

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**What screening tests has the child had (blood, hearing, vision, etc.)?**

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**What was the health of the parents at conception?**

Mother      Poor / Fair / Good / Excellent / Unknown

Father      Poor / Fair / Good / Excellent / Unknown

**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?** \_\_\_\_\_

**How was the mother's diet during pregnancy?**

Poor / Fair / Good / Excellent / Unknown

**Did the mother receive prenatal medical care?**

Y / N / Unknown

**Did the mother experience any of the following during the pregnancy?**

- High Blood Pressure
- Nausea
- Vomiting
- Diabetes
- Thyroid Problems
- Physical or emotional trauma
- Other \_\_\_\_\_

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

- Tobacco  Alcohol  Recreational drugs: \_\_\_\_\_
- Prescription medications: \_\_\_\_\_
- Over-the-counter medications: \_\_\_\_\_
- Supplements: \_\_\_\_\_
- Other: \_\_\_\_\_

**Birth History**

Term length:  Full  Premature: \_\_\_\_\_ wks  Late: \_\_\_\_\_ wks

Length of labour: \_\_\_\_\_ Weight at birth: \_\_\_\_\_

**Any complications?**

\_\_\_\_\_

**Was the birth:**  Vaginal  C-section  Induced  Forceps  Anesthesia used

**Did the child experience any of the following at or shortly after birth?**

- Jaundice  Rashes  Seizures  Birth injuries \_\_\_\_\_
- Birth defects \_\_\_\_\_
- Other \_\_\_\_\_

**How was the infant fed?**

- Breast fed. How long? \_\_\_\_\_  Formula. Milk/Soy/Other: \_\_\_\_\_
- Other: \_\_\_\_\_

**What foods were introduced before 6 months? (Please list approximate month as well.)**

\_\_\_\_\_  
\_\_\_\_\_

**6–12 months?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Did the child ever experience colic? Y / N How severe? Mild / Moderate / Severe**

**Does the child have any dietary restrictions (religious, vegetarian/vegan, etc.)?**

**Describe a typical day's diet:**

Breakfast:

\_\_\_\_\_

Lunch:

\_\_\_\_\_

Dinner:

\_\_\_\_\_

Snacks:

\_\_\_\_\_

Beverages (and total quantity):

\_\_\_\_\_

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

**At what age did the child first:**

Sit up \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_ Talk \_\_\_\_\_

**Describe the child's sleep pattern:**

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**How would you describe the child's temperament?**

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**How would you describe the child's behaviour and performance at school/daycare/or out in the community?**

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**Indicate if a close relative (parent, sibling) has had any of the following. Please specify who.**

- Allergies
- Asthma
- Birth Defects
- Juvenile arthritis
- Diabetes
- Kidney Disease
- Other
- I don't know the family medical history

**Does either of the parents have a chronic illness? Y / N Please describe:**

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**Is the child in:** School / Daycare / Home care / Other \_\_\_\_\_

**What are your child's favourite activities?**

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

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**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?**

- Natural Gas  Oil  Electric  Wood  Other \_\_\_\_\_

**Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)? Please describe.**

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**How would you describe the emotional climate of the child's home?**

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

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