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?

_____

Please list the medical professionals the child currently sees:

_____
_____
_____
_____

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

_____
_____
_____
_____
_____
_____
_____
_____

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

Condition	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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:

_____
(chemical/drug)

_____
(food)

_____
(other)

Number and Age of Siblings:

_____
_____

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

_____

_____

_____

_____

_____

_____

Please list any past prescription medications:

_____

_____

How many times has the child been treated with antibiotics?

_____

_____

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:

_____

_____

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

_____

_____

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

_____

_____

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:

_____

_____

_____

How would you describe the child's temperament?

_____

_____

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

_____

_____

_____

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:**

_____

_____

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?

☐ 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.

_____
_____
_____
_____
_____

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?

_____
_____
_____
_____
_____