

## Pediatric Intake Form

### Personal Information:

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

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

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: Male F

Weight: \_\_\_\_\_ Height / Length: \_\_\_\_\_

Parents/ Guardians names: 1. \_\_\_\_\_ Home # \_\_\_\_\_

Work/Cell \_\_\_\_\_

2. \_\_\_\_\_ Home # \_\_\_\_\_

Work/Cell \_\_\_\_\_

What are the living arrangements? \_\_\_\_\_

Any siblings? Y N If yes, who is oldest/youngest? \_\_\_\_\_

### How did you find out about us? (please check all that apply)

Yellow Pages

Friend

WebPage

Professional Referral

OAND

Other Whom should we thank? \_\_\_\_\_

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

(Would you like to be included in our email list?  Yes  No

### Health Care Practitioners:

Medical Doctor	
Chiropractor	
Massage Therapist	
Other	

Please list current health concerns in order of importance:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Prenatal History:

How did everyone react to the news of pregnancy? \_\_\_\_\_

What stresses were a part of life during the pregnancy? (work, emotional, physical, etc.) \_\_\_\_\_

How was Mom's health? (General) \_\_\_\_\_

( ) STD's (if yes, please specify) \_\_\_\_\_

( ) HIV ( ) Chicken Pox ( ) Hypertension ( ) Vomiting

( ) Toxemia ( ) Depression ( ) Gestational Diabetes ( ) Nausea

How much exercise did Mom get? \_\_\_\_\_

What were the first foods given? Were there any reactions? (please be specific)

\_\_\_\_\_

Are there any foods that the child will not eat? \_\_\_\_\_

What are the favourite foods? \_\_\_\_\_

Would you consider the child to be a finicky eater? Y N

- **Please attach Diet Diary for one week including portions, times and moods.**

**Social Behaviour:**

Is the child in ( ) playgroup ( ) daycare ( ) preschool ( ) school?

How does the child get along with his/her peers? \_\_\_\_\_

How much time does the child spend indoors each day? \_\_\_\_\_ Outdoors? \_\_\_\_\_

What are his/her favourite activities? \_\_\_\_\_

Does he/she play any sports? \_\_\_\_\_

Does he/she belong to any clubs? \_\_\_\_\_

**Home Life:**

Who lives with the child? \_\_\_\_\_

Are there any pets? Y N

If yes, what kind and how old was the child when the pets were brought home?

\_\_\_\_\_

Is the child exposed to any smoke? \_\_\_\_\_

How many family dinners per week? 1 2 3 4 5 6 7

What physical surroundings are near the home? (parks, trees, highways, powerlines, etc.)

\_\_\_\_\_ How old is the home? \_\_\_\_\_

Have there been any renovations during the child's time there? Y N

If yes, what was done and when? \_\_\_\_\_

\_\_\_\_\_

Please briefly describe the child's personality (good and bad, behavioural problems):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**General Review of Systems:**

Skin: Have you noticed any lumps, bumps, changes in colour? \_\_\_\_\_

Head: Does it appear too large/small, any bumps or trauma? \_\_\_\_\_

Eyes: Any infections, trauma, pain? \_\_\_\_\_

Nose and sinuses: Recurrent infections, pain, trauma? \_\_\_\_\_

Mouth and throat: Tonsils still there, infections, dental work? \_\_\_\_\_

Respiratory: Ever turned blue, bronchitis, coughs, colds, wheeze? \_\_\_\_\_

**Vaccinations:**

	Hepatitis		DPT
	HiB (or HbCV)		IPV (Injected polio vaccine)
	OPV (Oral polio vaccine)		MMR (Measles, Mumps, Rubella)
	Varivax (Chicken Pox vaccine)		

Were there any complications? If so, what were they and which vaccine were they with?

Have there been any visits to the hospital? If yes, why and how long was the stay?

How many times have you used antibiotics? \_\_\_\_\_

Have there been any reactions to medications? \_\_\_\_\_

**Family History:**

Please indicate who was affected by what (ie: Mother’s mother/father, sibling, aunt, etc.)

	Diabetes		Cancer
	Heart Disease		High Blood Pressure
	Stroke		Blood Disorders
	Arthritis		Allergies
	Obesity		Cystic Fibrosis
	Alcoholism		Mental Illness
	Depression		Learning Disabilities
	Congenital Defects		SIDS (sudden infant death)
	Kidney Disease		Ulcers
	Liver Disease		Other

**Developmental Milestones:** (please fill in what age they were achieved)

Hold Head Erect	Roll over
Sit alone	Walk alone
Cut first tooth	Say first words (that had meaning)
Speak in sentences	Toilet Trained
Tie shoes	Dress without help

**Sleep:**

Does the child sleep through the night? Y N If yes, since what age? \_\_\_\_\_  
If no, how many times does he/she wake and why? \_\_\_\_\_  
How many hours a night does the child sleep? \_\_\_\_\_  
What position does the child sleep in? \_\_\_\_\_  
How long does it take for the child to fall asleep? \_\_\_\_\_  
Are there any dreams to speak of (good or bad)? \_\_\_\_\_  
How is the child in the morning with respect to mood? \_\_\_\_\_

**Feeding:**

Was the child breast fed? Y N If yes, how long? \_\_\_\_\_  
Was the child bottle fed? Y N If yes, how long? \_\_\_\_\_  
Any reactions? \_\_\_\_\_  
When was solid food introduced? \_\_\_\_\_  
Did Mom smoke? Y N  
Was Mom exposed to smoke? Y N If yes, how much? \_\_\_\_\_  
Did Mom do any recreational drugs? Y N If yes, please specify: \_\_\_\_\_  
Was Mom exposed to any radiation? Y N  
Did Mom have any cravings or aversions? (Please specify what it was, and at what time during the pregnancy.) \_\_\_\_\_  
\_\_\_\_\_  
Any medications and/or natural supplements used? \_\_\_\_\_  
\_\_\_\_\_

**The Birth:**

Who attended? \_\_\_\_\_  
What was the mood? \_\_\_\_\_  
Where was it? (at home, hospital, birthing centre) \_\_\_\_\_  
Type of delivery? ( ) Vaginal ( ) Cesarean  
Any instruments required? (forceps, suction, etc.) \_\_\_\_\_  
\_\_\_\_\_  
Any complications? \_\_\_\_\_  
\_\_\_\_\_  
Was it ( ) full term ( ) preterm ( ) late term?  
What was the number of weeks carried? \_\_\_\_\_  
How long was labour? \_\_\_\_\_

Any medications used? \_\_\_\_\_

APGAR Scores: at birth \_\_\_\_\_ at five minutes \_\_\_\_\_

Weight: \_\_\_\_\_ Length: \_\_\_\_\_

**Neonatal History:**

Please check what applied to the patient right after birth:

Vitamin K  Circumcision  Antibiotics  Surgery

Medications  Other: \_\_\_\_\_

Jaundice  Colic  Breathing Abnormalities

Congenital Abnormalities

**Medical History:**

<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Chicken Pox
<input type="checkbox"/>	Croup	<input type="checkbox"/>	Ear Infection
<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>	Rubella (German Measles)
<input type="checkbox"/>	Herpes	<input type="checkbox"/>	Impetigo
<input type="checkbox"/>	Lyme Disease	<input type="checkbox"/>	Measles
<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	Mononucleosis
<input type="checkbox"/>	Mumps	<input type="checkbox"/>	Pink eye
<input type="checkbox"/>	Pinworms	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	Poison Oak/Ivy Sumac	<input type="checkbox"/>	Poliomyelitis
<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Ringworm
<input type="checkbox"/>	Roseola	<input type="checkbox"/>	Tetanus
<input type="checkbox"/>	Thrush/(oral fungal infection)	<input type="checkbox"/>	Toxoplasmosis
<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Strep Throat