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PEDIATRIC INTAKE FORM

Name: _____ Date: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Parent's Email: _____

Male ☐ Female ☐ Age: _____ Date of Birth: _____

Child lives with: _____

Emergency Contact: _____ Phone: _____ Relation: _____

How did you hear about our practice? _____

Would you like to receive our newsletter by email? Yes ☐

HEALTH CONCERNS

Please, list your health concerns in order of importance.

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

Vitamins and Supplements

List all vitamins/minerals/herbal supplements your child is currently taking:

_____
_____
_____

Medications

List all prescription and non-prescription medications your child is currently taking: _____

Medical History

List any major illness, injuries and/or surgeries that your child has had and when:

_____

_____

_____

Has your child ever experienced any of the following?

- ☐ Rubella
- ☐ Mumps
- ☐ Measles
- ☐ Chickenpox
- ☐ Whooping cough
- ☐ Scarlet fever
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Colic
- ☐ Diaper rash
- ☐ Cradle cap
- ☐ Diarrhea
- ☐ Constipation
- ☐ High fever
- ☐ Bedwetting
- ☐ Strep throat
- ☐ Frequent colds
- ☐ Sleep problems
- ☐ Stomach aches
- ☐ Headaches
- ☐ Ear infections
- ☐ Hives
- ☐ Rashes
- ☐ Eczema
- ☐ Other illness/diseases: _____

_____

Vaccinations (Please check)

- ☐ DPT (Diphtheria, Pertussis, Tetanus)
- ☐ MMR (Measles, Mumps, Rubella)
- ☐ Chicken Pox
- ☐ Polio
- ☐ Flu Shot
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Other: _____

Did your child experience any adverse effects from vaccinations? If yes, please explain:

_____

_____

Allergies

Does your child have any medical allergies or sensitivities? Please list:

_____

General

Height: _____ Weight: _____ lbs Weight 1 year ago:_____ lbs

Family History

Please put an "L" for living and "D" for deceased and present age or age at time of death. Indicate if the family member suffered from any disease or conditions such as cancer, high blood pressure, heart attack, stroke or diabetes.

Relationship	L/D	Age	Health Conditions/Cause of Death
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sister (s)			
Brother (s)			

Parental health history

Was this child adopted? Yes☐ No☐ If yes, at what age? ☐

Mother's age at time of child's birth_____ Father's age at the time of child's birth____
Did the mother receive medical care during the pregnancy? Yes☐ No☐

Did the mother experience any of the following during pregnancy? Yes☐ No☐

☐Bleeding ☐Nausea ☐Physical/emotional trauma
☐Vomiting ☐Thyroid Problems ☐Other:
☐High blood Pressure ☐Diabetes

Were any of the following interventions used during pregnancy?
☐Ultrasound ☐Chorionic Villi Sampling ☐Triple screen
☐Amniocentesis ☐ Maternal serum screening ☐Other: _____

Did the mother use any of the following during pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational drugs

Prescription medications: _____

Over the counter medications: _____

Vitamins and/or supplements: _____

Birth History

Term length

☐ Pre-term (less than 37 weeks) ☐ Full term (38-42 weeks) ☐ Post-term (43+ weeks)

_____ Wks _____ Wks _____ Wks

Type of birth: ☐ Vaginal ☐ C-section

Interventions:

☐ Induction ☐ Epidural/anesthesia ☐ Other:

☐ Use of forceps ☐ Episiotomy

Were there any complications during delivery (e.g. Breech)? _____

Length of labour_____ hrs Weight of infant at birth:_____ kg/lbs

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

☐ Jaundice ☐ Infections: _____

☐ Rashes ☐ Birth Injuries: _____

☐ Seizures ☐ Birth defects: _____

☐ Difficulties with feeding: _____

Health and Development

At what age did your child first:

Sit up _____ Crawl _____ Walk _____ Talk _____

At what age did your child start teething?_____

Nutritional History

How was your infant fed? ☐ Breastfed ☐ Formula: Cow's milk/Soy/Other

For how long? _____ _____

Did your infant experience any reactions to the breast milk or formula?
If yes, please explain: _____

What foods were introduced before 6 months? Please list the approximate month and any reactions:_____

What foods were introduced between 6 and 12 months? Please list the approximate month and any reactions: _____

Typical Food Intake

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
To Drink: _____