

PEDIATRIC INTAKE FORM

This information is strictly confidential and is only used in accordance with our privacy policy.

Child's name: _____ Age: _____ Grade: _____

Date of birth: _____ Sex: M / F

Address: _____

Postal Code : _____

Parent or Guardian name & number(s): _____

Who is authorized to escort your child for consultations at our clinic? _____

Please list your main health concerns in order of importance to you:

1. _____
2. _____
3. _____
4. _____

Please list your child's present health care provider with their designation (ie. Pediatrician)

Does your child have any known contagious diseases at this time?

Medications and supplements (Please mark "C" for current use, and "P" for past use)

Aspirin	Vitamins
Tylenol	Minerals
Antibiotics	Fluoride
Other:	Other:

Childhood Illnesses – please check those that your child has experienced

Chicken pox	Scarlet fever	Mononucleosis
Measles	Rheumatic fever	Ear infection
Mumps	Strep throat	Tonsillitis
Rubella	Pneumonia	Whooping cough

Immunization history (please list what, when, and if any reaction):

Vaccine	Yes / No	Reaction	Vaccine	Yes / No	Reaction
MMR			Hepatitis B		
DPT			Influenza		
Hepatitis A			Polio		
Tetanus			Smallpox		

Child's birth history

Term: Full ____ Premature ____ weeks Post date ____ weeks Birthweight ____
 Length of labour ____ Any complications?

Birth: Vaginal ____ C-section ____ Induced ____ Forceps or suction ____ Anaesthesia ____
 Breast fed N / Y If yes, how long? ____
 Formula fed N / Y If yes, how long and what type? ____

Age solid foods introduced: ____

What foods and in what order?

Does the child have any food allergies or aversions?

What screening tests has your child had (ie. Hearing, vision):

Describe the child's sleep patterns:

Age child began: Sitting ____ Crawling ____ Walking ____ Talking ____

Does the child have any environmental allergies: _____

Sample daily diet including liquids:

Hospitalizations/surgeries/accidents/serious injuries and illnesses (please describe and date):

Family History – please identify family members who have had the following, if any:

Alcoholism	Diabetes	Hypoglycemia
Allergies	Eczema	Mental illness
Anemia	Epilepsy	Stroke
Arthritis	Heart disease	Other
Asthma	Hearing loss	

Child's Health History

	Now	Past	Never		Now	Past	Never
Allergies				Fatigue			
Anemia				Headaches			
Asthma				Heart murmur			
Bedwetting				High fever			
Birth defect				Hyperactivity			
Colic				Insomnia			
Cough				Jaundice			
Croup				Learning problems			
Depression				Moodiness			
Diarrhea				Stuffy nose			
Dry skin				Thrush			
Earache				Vomiting			
Eczema							

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