Pediatric Intake Form

Personal Information:
Child's Name: ____
Address: ____
City: _________________________ Postal Code: _________________
Telephone: (______) ______ - ____________ Work: (______) ______ - ____________
Birthdate: _______________________ Age: ________ Gender: M F
Weight: _____________ Height / Length: ________________
Emergency Contact: ______________ Phone: (______) ______ - ____________
Parents / Guardians names: ______________________________________
What are the living arrangements? __________________________________
Any siblings? Y N If yes, who is oldest/youngest? ______________________

Health Care Practitioners:

Medical Doctor:
Chiropractor:
Massage Therapist:
Other:

Please list current health concerns in order of importance:

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____
____
____

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 (Diptheria, Pertussis, Tetanus)
	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:

	Asthma		Chicken Pox
	Croup		Ear Infections
	Eczema		Tuberculosis
	Whooping Cough		Rubella (German Measles)
	Herpes		Impetigo
	Lyme Disease		Measles
	Meningitis		Mononucleosis
	Mumps		Pinkeye
	Pinworms		Pneumonia
	Poison Oak / Ivy / Sumac		Poliomyelitis
	Rheumatic Fever		Ringworm
	Roseola		Tetanus
	Thrush (oral fungal infection)		Toxoplasmosis
	Epilepsy / Seizures		Strep Throat