Paediatric Intake Form

Child's Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

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

Parent/ Guardian's Names: _____

Address (if not same as above): _____

Phone (home): _____ (work): _____ (cell): _____

Name of Medical Doctor: _____ Phone: _____

How did you hear about us? Friends Family Presentation Website Newspaper Other:

This is a confidential record of your medical history and will be kept in this office. Information contained in it will not be released to any person unless authorized by you in writing.

Health Concerns

What are the main health concerns, in order of importance?

Vitamins and Supplements

Please list all vitamins/ mineral/ herbal supplements the child is currently taking:
*** Please bring all supplements to initial visit***

Supplement (Including brand)	Dosage	When did you begin taking this supplement?

Medications

Please list all prescription and non-prescription medications the child is currently taking:
Please bring in all medications to initial visit

Medication	Dosage	When did you begin taking this medication?

Please list all prescription medications the child has taken in the past. How long did they take each medication?

Family Health History

Next to each family member listed below, please indicate if the person is living (L) or deceased (D). Include present age or age at time of death. Please note if the family member suffered from any disease such as cancer, high blood pressure, heart attack, stroke, diabetes, skin disorders, asthma, allergies, arthritis, depression, hayfever, mental illness, tuberculosis, epilepsy, etc.

Relationship	L/D	Age	Disease suffered/ Cause of death
Mother			
Father			
Maternal Grandfather			
Maternal Grandmother			
Paternal Grandfather			
Paternal Grandmother			
Sister(s)			
Brother(s)			
Maternal Aunts			
Maternal Uncles			
Paternal Aunts			
Paternal Uncles			

Health History

Please list any injuries, traumatic events, accidents, and/or major surgery the child had in the past, and when they occurred:

Vaccinations (please check):

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

Did the child experience any adverse effects from any of these vaccinations? If yes, please explain:

Mother's Health History

Mother's age at child's birth:		
Mother's health during pregnancy (please check those that apply):		
bleeding	nausea	physical or emotional trauma
hypertension	diabetes	thyroid problems
cigarette/ alcohol/ drug consumption (please circle)		
medications:	other:	

Childhood Illnesses (check all that apply)

___ chickenpox	___ scarlet fever	___ pneumonia	___ measles
___ mumps	___ rubella	___ rheumatic fever	___ frequent colds
___ tonsillities	___ ear infection	___ diphtheria	___ pertusis
other:			

Current Symptoms (check if current; please use 'P' if past symptom)

___ burning/ painful urination ___ frequent urination ___ bed wetting ___ blood in urine ___ diarrhea ___ constipation ___ body/ breath odour ___ change in appetite ___ frequent vomiting ___ stomach aches ___ blood in stools	___ eczema ___ nosebleeds ___ easy bruising ___ sore throats ___ wheezing ___ cough ___ hearing loss ___ ringing in ears ___ ear infection ___ skin conditions (warts, abscess, cold sores, rash, etc)	___ sleep problems ___ night sweats ___ grinding teeth ___ cries easily ___ hair loss ___ dizzy spells ___ tendency to bleed ___ seizures ___ fatigue
Other:		

Birth History

Term (please check):	___ full	___ premature	___ late
Weight at birth:	Length of labour:	Complications:	
Was delivery by C-section or vaginal birth? (please circle)			
Did your infant experience any of the following at birth or soon after?			
___ jaundice ___ rashes	___ colic	___ seizures	___ birth defects ___ birth injuries
Other:			
General Information:			
Child's sleep patterns (first year): (describe)			
Age began:			
sitting _____	crawling _____	walking _____	talking _____

Diet Information

Feeding:	___ breast fed	how long?
	___ formula	
	___ milk: cow/goat/soy/ other:	when started?
Age when solid foods were first introduced:		
Which foods were introduced first?		
Food intolerance/ allergies:		

Diet in a Typical Day:

Breakfast	Lunch	Dinner	Snacks
Snacks:			
Food desires:			
Food dislikes:			