



Confidential Pediatric Intake Form

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Patient Name: _____

Date: _____

Who is filling out this form?

Name: _____

Relation: _____

Parents/Guardians:

Names: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Address: _____

City: _____

Province: _____

Postal Code: _____

Other Health Care Providers (name and phone number):

1. _____

Phone: _____

2. _____

Phone: _____

3. _____

Phone: _____

What health concerns brought you in today? Please list in order of importance

1. _____

2. _____

3. _____

Please list all drugs and medications which are currently prescribed, the reason and for how long:

1. _____

How long? _____

2. _____

How long? _____

3. _____

How long? _____

Please list all supplements or botanical medicines that you are currently using, the reason and for how long:

1. _____

How long? _____

2. _____

How long? _____

3. _____

How long? _____



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Pregnancy

Please check any of the following that applied to the pregnancy:

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Alcohol/Drug Abuse |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Infections | <input type="checkbox"/> Other: | |

Mother's age for this pregnancy: _____

of previous pregnancies: _____

of previous miscarriages: _____

1. During this pregnancy was there any physical or emotional trauma (accidents, abuse, death in the family, etc.)?

2. What medications and supplements were taken (if any)?

3. Any exposure to disease? What disease?

4. Where was the birth? What was the name of the hospital?

Please indicate if any of the following interventions were applied:

- | | | | |
|--|--|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Induction | <input type="checkbox"/> Episiotomy | <input type="checkbox"/> Pitocin | <input type="checkbox"/> Forceps |
| <input type="checkbox"/> Vacuum extraction | <input type="checkbox"/> Pain medication | <input type="checkbox"/> C-Section | <input type="checkbox"/> Epidural |
| <input type="checkbox"/> Other: | | | |

How long was the labour (hours)? _____

Full term or pre-term (weeks) _____

Infant weight: _____

Length: _____

Head Circumference: _____

APGAR score (if known): birth: _____

1min: _____

5min: _____



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Please indicate any of the following that apply:

- Congenital Defects Infections Respiratory Distress Jaundice
- Anemia Poor feeding Colic Rashes
- Other:

Infancy

Was the infant breastfed? _____ For how long? _____

Was the infant formula fed? _____ Which formula was used? _____

When was solid food introduced? _____ Which food? _____

Are there any foods that are excluded from your child's diet?

Please indicate any of the following vaccinations that have been given:

- Diptheria Measels Chicken pox Pertussis Mumps
- Flu shot Tetanus Rubella Polio Hepatitis
- Other:

Any adverse reactions from any of the above?

Any previous hospitalizations or surgeries?

Family Health History

Family Member	Age	Illness
Mother		
Father		
Siblings		
Maternal grandmother		



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Maternal grandfather		
Paternal grandmother		
Paternal grandfather		

General Health

Current weight: _____ Height: _____

School/Day Care performance (general):

Interests:

Has the child been diagnosed with any learning disabilities? If so, what disability?

Favorite activity:

Exercise (how often, how long):

Does any family member smoke?

Any pets in the home? What kinds?

Sleep (please describe)?