Intake Package Pediatric

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Please bring this fully completed form to your first visit

Confidential Patient Information Date: _____

Patient's Name: _____ Date of Birth: _____ Age: _____ Sex: M F
(dd/mm/yyyy)

Name of Parent(s) / Guardian: _____

Full address: _____
(Street Address / City / Province / Postal Code)

Telephone: _____ / _____ / _____
(Home) (Mobile) (Business)

Email(s): _____

Emergency Contact: _____ _____ _____
Full Name Relation Telephone

Patient's Primary Caregiver / Physician: _____ _____
Telephone

Please complete the following questions

What are the main health concerns that bring you here today?
(Please list as many as applicable and in order of importance. You may include the onset, location, previous treatment etc of any of these concerns)

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

Medications: Please list any current (c) or previous (p) medications the patient is taking

_____
_____
_____

Please list any vitamins, herbs, homeopathies, or supplements the patient is currently taking

_____
_____
_____

Allergies: Please list any allergies the patient has (ie- medications, foods, chemicals)

_____
_____
_____

Immunization: Please check any vaccinations the patient has received and any reactions that followed

☐ MMR	Reactions: _____	☐ DPT	Reactions: _____
☐ HepB	Reactions: _____	☐ Chickenpox	Reactions: _____
☐ Influenza (Hib)	Reactions: _____	☐ Polio	Reactions: _____

Health History: Please mark "N" for now, "P" for past, "B" for both

_____ Anxiety	_____ Frequent Colds	_____ Headaches	_____ Influenza
_____ Chicken Pox	_____ Bed Wetting	_____ Couch/Wheezing	_____ Runny Nose
_____ Measles	_____ Food Sensitivities	_____ Asthma	_____ Nose Bleeds
_____ Mumps	_____ Gas/Bloating	_____ Jaundice	_____ Dizziness
_____ Rashes / Hives	_____ Pneumonia	_____ Diarrhea	_____ Nightmares
_____ Ear Infections	_____ Fractures	_____ Constipation	_____ Bladder Infection

Other: _____
_____
_____
_____

Surgeries / Hospitalizations: Please include dates and or reasons for the following:

_____
_____
_____

Family History: Please indicate family member to which history applies

Allergies		Heart Disease	
Multiple Sclerosis		Multiple Dystophry	
Asthma		High Blood Pressure	
Eczema		Kidney Disease	
Cancer		Mental Illness	
Seizers		Cerebral Palsy	
Endocrine Disease		Migraines	
SIDS		Mentally Handicap	
Diabetes		Depression	

Other: _____

Any siblings? Y N If yes, please indicate names and ages: _____
_____
_____

Are parents divorced or separated? Y N If yes, with whom does the child live? _____

Any Pets? Y N If yes, what type(s)? _____

Birth History: Birth Weight: _____ Birth Height: _____ APGAR Score: _____
Type of Birth: ☐ Vaginal, ☐Caesarian Any interventions used (ie- Forceps): _____
Location: ☐ Hospital, ☐ Home, ☐Other: _____ If hospital, length of stay: _____
Complication to mother or baby: Y N If yes, describe: _____
Length of Labour: _____ Term: ☐ Premature, ☐ to term, ☐ late, ☐ induced
Age of parents at birth: _____ Pounds gained by mom during pregnancy: _____
Did mother smoke during pregnancy? Y N If yes, how much? _____
Any alcohol / drugs consumed during pregnancy: _____ If yes, how often? _____

Neonatal History: Please check any that apply

☐ Jaundice	☐ Heart problems	☐ Scoliosis
☐ Colic	☐ Cleft palate/lip	☐ Cataracts / glaucoma
☐ Respiratory problems	☐ Spina bifida	☐ Hip problems

Other: _____

Developmental Milestones: Please indicate age

_____ Teething	_____ Pulled self up	_____ First sentences	_____ Tied shoe laces
_____ Sat alone	_____ First steps	_____ Fed self	_____ Toilet trained
_____ Rolled over	_____ First words	_____ Dressed self	_____ Rose a bike

Compared to others in family, development was ☐ slow, ☐ average, ☐fast

Nutrition:
Was child breast fed? Y N If yes, for how long? _____ What age were foods introduced: _____
1st foods: _____ Any reactions: _____
Does child have good appetite? Y N How many meals per day? _____
What are child's favourite foods? _____
Does the child have any diet restrictions? Y N If yes, please list: _____

24-hour typical diet diary: Include typical amounts

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages:_____

Education: School Name: _____ Phone Number: _____
Type of school: ☐ public ☐ private ☐ home school ☐ other: _____
Grade: _____ Please check if applicable: ☐ special education ☐ gifted program
Has the child even been held back in school? Y N If yes, which grade(s)? _____
Does the child enjoy school? Y N What are the usual grades received? _____
Which subjects does the child enjoy? _____
Which subjects does the child dislike? _____

Housing: please check what is applicable
☐ Apartment ☐ House ☐ Carpeting ☐ Electric heat ☐ Gas heat
How old is the home? _____ Any recent renovations? _____
Does the home contain any mold, excess dust, fungus, etc? Y N What type? _____
Location of home: Close to ☐ powerlines ☐ airport ☐ highway ☐ trees ☐ industry

Habits: Does he/she exercise regularly? Y N What activities and how often? _____
_____
How much time does the child spend outdoors? _____
How much sleep per night? _____ Do they wake feeling rested? Y N
Do they have nightmares / night terrors? Y N If yes, how often? _____
At what age did the child first sleep through the night? _____
Do they watch television? Y N If yes, how many hours per day? _____
Do they read books? Y N If yes, how many hours per day? _____
Do they have many friends? Y N Do they make friends easily Y N
What are the child's interests? _____

Review of Systems: Please put an "N" for now, "P" for past, "B" for both

Mental / Emotional
_____ Anxiety / Fears
_____ Depression
_____ Weeps easily
_____ Mood swings
_____ Poor concentration
_____ Memory problems

Skin / Hair
_____ Rashes
_____ Easily bruised
_____ Diaper rash
_____ Hives
_____ Acne
_____ Eczema
_____ Lice / nits
_____ Itching
_____ Hair loss

Head
_____ Headaches
_____ Fever
_____ Migraines

Nose / Sinuses
_____ Frequent colds
_____ Seasonal allergies
_____ Chronic runny nose
_____ Nose bleeds
_____ Sinus problems
_____ Loss of smell

Ears
_____ Earaches
_____ Loss of hearing
_____ Dizziness / ringing

Mouth / Throat
_____ Frequent sore throat
_____ Cavities
_____ Sores in mouth

Immune
_____ Frequent infections
_____ Swollen glands
_____ Slow wound healing

Respiratory
_____ Shortness of breath
_____ Asthma
_____ Frequent cough
_____ Bronchitis
_____ Wheezing
_____ Cough blood

Cardiovascular
_____ Palpitation
_____ Chest pain

Gastrointestinal
_____ Stomach aches
_____ Diarrhea
_____ Constipation
_____ Bloating / gas
_____ Change in appetite
_____ Change in thirst

Genitourinary
_____ Frequent infections
_____ Dribbling
_____ Bedwetting
_____ Frequency at night

Musculoskeletal
_____ Muscle aches
_____ Stiffness
_____ Cramps / spasms

Thank you for taking the time to fill out this questionnaire.
It will help greatly in our study of your present health concerns and in our understanding of your health goals.
Your responses will assist us in choosing the appropriate treatment that will hopefully bring about your return to optimal health.