

CHILD INTAKE FORM

CONTACT INFORMATION

Child's Name _____ Age _____ Birthdate(D/M/Y) _____

Address _____ City _____ Postal Code _____

Parent/Caregiver Names _____

Phone (Home) _____ Cell: _____ Email _____

Emergency Contact _____ Contact Number _____

Physician or Pediatrician Name _____ Phone Number _____

Siblings (Names and Ages) _____

How did you find out about our office? _____

CHILD'S CURRENT HEALTH CONCERNS

What is your main reason for coming in today? _____

Please list, in order of importance, any other health concerns that you may have pertaining to the child:

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

What kind of treatment have you received for the above? _____

Have any of the above conditions been diagnosed? Yes/No If yes, by whom? _____

Please list any medications (including over-the-counter) that your child has taken:

Presently

In the past

FAMILY HISTORY

What was the age of the parents at the time of conception? Mom: _____ Dad: _____

What was their general state of health at that time?

Mom: Excellent ___ Good ___ Average ___ Fair ___ Poor ___

Dad: Excellent ___ Good ___ Average ___ Fair ___ Poor ___

Please indicate which of the following conditions apply to your immediate family:

Allergies		Arthritis		Asthma		Auto-immune disease	
Birth defects		Bleeding disorders		Cancer		Deafness	
Depression		Diabetes		Eczema		Heart disease	
Hepatitis		Herpes		HIV/AIDS		Hypertension	
Kidney disease		Mental illness		Peptic ulcer		Thyroid disease	
Tuberculosis		Visual problems		Speech problems		Frequent infections	

Other: _____

PRENATAL HISTORY

Please indicate if any of the following conditions were experienced by mom during pregnancy:

Diabetes		Edema (swelling)		Emotional trauma		Depression	
Fainting		German measles		Herpes		Infections	
Nausea		Physical trauma		Pregnancy induced hypertension		Thyroid problems	
Toxemia		Vomiting		Excessive weight gain		Weight loss	

Please list any medications taken during pregnancy (including over-the-counter): _____

Did mom use any of the following during pregnancy? Please indicate how much and for how long.

Alcohol		Tobacco	
Hormone		Coffee	
Cortisone		Laxatives	
Sedatives		Antacids	
Recreational drugs		Aspirin or Tylenol	

Please list any supplements/herbs taken during pregnancy: _____

How would you describe the pregnancy? _____

Was there any history of a complicated pregnancy prior to the birth of this child? _____

BIRTH HISTORY

Length of gestation _____

Length of labour _____ Was labour spontaneous? **Yes/No** If no, how was it induced? _____

Type of delivery **Vaginal** ___ **C-section** ___ **Emergency C-section** ___

Location of delivery **Home** ___ **Hospital** ___ **Birthing center** ___ **Other:** _____

Were there any interventions used at birth? **Anesthesia** ___ **Epidural** ___
Episiotomy ___ **Forceps** ___ **Vacuum** ___ **Other:** _____

At birth, what was the child's: **Apgar Score** _____ **Weight** _____ **Length** _____

Please indicate if any of the following conditions were experienced by your child at or soon after birth:

Allergic reaction		Failure to thrive		Respiratory distress		Billi-lights	
Birth defects		Hypoxia		Seizures		Respirator	
Colic		Jaundice		Unusual weight gain		Surgery	
Difficulty feeding		Meningitis		Weight loss		Incubation	
Fevers		Rashes		Meconium (in the lungs)		Drug administration	

CHILD'S HEATH HISTORY

Does your child sleep through the night? **Yes/No** Hours of sleep nightly: _____

Does your child nap during the day? **Yes/No**

Does your child experience frequent nightmares? **Yes/No**

Does your child have any known allergies? _____

Has your child ever been hospitalized (please list reason and dates)? _____

Which of the following conditions apply to your child? Please indicate if **now (N)** or in the **past (P)**.

	N	P		N	P		N	P		N	P
Allergies			Diarrhea			Hair loss			Rheumatic fever		
Asthma			Ear infections			Hearing problems			Rubella		
Bed wetting			Easy bleeding			Lice			Scarlet fever		
Bladder infections			Easy bruising			Measles			Seizures		
Bloody urine			Eczema			Meningitis			Sleeping problems		
Body/breath odour			Emotional trauma			Mood changes			Sore throat		
Bronchitis			Eye infections			Mumps			Stomach flu		
Burning urine			Fatigue			Nausea			Strep throat		
Chicken pox			Fever			Nervousness			Tonsilitis		
Frequent colds			Fractures			Night sweats			Unusual fears		
Cough			Frequent urination			Nose bleeds			Vision problems		
Constipation			Fungal infections			Pneumonia			Vomiting		
Croup			Gas			Physical trauma			Bone pain		
Cradle cap			Growing pains			Rash			Whooping cough		

IMMUNIZATION HISTORY

Has your child ever traveled outside of Canada? **Yes/No** If yes, where? _____

Please indicate approximate dates of immunizations where possible and relevant:

Measles, Mumps, Rubella _____ Polio _____
 Small Pox _____ Influenza _____
 Chicken Pox _____ Hepatitis _____
 Diphtheria, Pertussis, Tetanus (DPT) _____

Did your child experience any adverse or odd reactions to the immunizations? **Yes/No**

If yes, please describe _____

NUTRITIONAL HISTORY

Was your child breastfed? **Yes/No** If yes, for how long? _____

If your child was not breast fed, please indicate what food was used. If possible, include the brand.

What was the first liquid introduced to your child after this (excluding water)? _____

Please make a brief list of solid foods given in the rough order of introduction.

<u>Food</u>	<u>Age of Introduction</u>	<u>Adverse Reaction</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

How would you describe your child's eating habits? _____

Please provide a rough outline of your child's daily diet:

Breakfast	
Lunch	
Dinner	
Snacks	
Water intake	
Other fluids	
Nutritional supplements	

SOCIAL HISTORY

How would you describe your child's temperament? _____

How does your child interact with others (adults and other children)? _____

How does your child handle stressful situations? _____

How does your child express his/her emotions? _____

How would you describe your child's performance at school/daycare? _____

How do you think others would describe your child? _____

Does your child take part in any extracurricular activities? _____

HOME ENVIRONMENT

How many people live in your home? _____ Are there any smokers in your home? **Yes/No**

Do you have any pets? _____

How old is your home (approximately)? _____ How is your home heated? _____

In general, how would you describe the emotional climate in this child's household? _____

Is there anything else that you would like to tell me about your child? _____

Thank you for taking the time to fill out this lengthy questionnaire!
It will be a valuable resource in helping to understand your child's health.

Looking forward to seeing you in the near future.