

Pediatric Intake

Please complete the following form in order to provide us with the background information we require to ensure you receive comprehensive care. It should take 10-15 minutes.

Contact Information:

Child's Name	_____	School Name	_____
Date of Birth	_____	School Phone	() _____
Child's Age	_____	School Address	_____
Sex (circle one)	Male Female	OHIP Number	_____

List contact information in order of preference:

Primary Contact:

Name	_____	Home Phone	_____
Relationship to Child	_____	Work Phone	_____
Address	_____	Mobile Phone	_____
	_____	Email	_____

Secondary Contact:

Name	_____	Home Phone	_____
Relationship to Child	_____	Work Phone	_____
Address	_____	Mobile Phone	_____
	_____	Email	_____

Care Co-ordination:

Medical Doctor	_____	Specialist	_____
Medical Doctor #	() _____	Specialist #	() _____
Medical Doctor Address	_____	Specialist Address	_____
Medical Doctor Email	_____	Specialist Email	_____
Dentist	_____	Additional	_____
Dentist #	() _____	Additional #	() _____

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Please List any other Medical Providers:

Type of Medical Provider	Name	Phone #	Address

Chief Concerns:

List your main health concerns (or reasons for visiting the clinic) in order of importance

1. _____

2. _____

3. _____

4. _____

Medical History:

How would you describe your child's general state of health? (circle one) excellent good fair poor

Medical conditions: Please indicate any serious illnesses, conditions, or reasons for hospitalizations

Medical Condition/ Hospitalization	Date of Diagnosis/ Diagnosed by whom	Is the condition still present	Symptoms

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Allergies or Food sensitivities: Please indicate any allergies and/or serious food sensitivities

Allergy/Sensitivity	Severity of reactions

Past Conditions

Illness	Circle One	Age	Duration	Complications / Hospital Admittance
Asthma	Yes No			
Cold & Influenza	Yes No			
Fever (above 105F)	Yes No			
Cough	Yes No			
Jaundice	Yes No			
Diabetes	Yes No			
Ear infections	Yes No			
Measles	Yes No			
Mumps	Yes No			
Rubella	Yes No			
Whooping Cough	Yes No			
Chicken Pox	Yes No			
Rheumatic Fever	Yes No			
Scarlet Fever	Yes No			
Polio	Yes No			
Strep throat	Yes No			
Mononucleosis	Yes No			
Impetigo	Yes No			
Eczema	Yes No			
Warts	Yes No			

Medications/Supplements: Please list all current medications/supplements

Medication/Supplement	Dose (if known)/ Length of Use	Prescribing Physician	Condition it is treating

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Has your child taken anti-biotics within the last 5 years (circle one)? YES NO
 How many times have you taken anti-biotics within the last 5 years _____

Vaccinations: Please indicate which vaccinations you have received.

Vaccination against:	Circle One	Age	Side Effects / Hospital Admittance
Measles, Mumps, Rubella (MMR)	Yes No		
Diphtheria, Pertussis, Tetanus (DPT)	Yes No		
Haemophilus Influenza B (Hib)	Yes No		
Chicken Pox (Varicella Zoster)	Yes No		
Rabies	Yes No		
Hepatitis A	Yes No		
Hepatitis B	Yes No		
Tetanus	Yes No		
Polio	Yes No		
Flu	Yes No		
Other:			

Prenatal History

What was the general health of the mother during pregnancy? (circle) Excellent Good Fair Poor Unknown

Was the mother exposed to any of the following during pregnancy (check the box next to the listed exposure)?

alcohol		radiation		trauma	
tobacco		chemotherapy		stress	
recreational drugs		excessive UV		OTHER:	
prescription drugs		infectious disease			

Pregnancy Complications: check the box next to the listed complication

nausea / vomiting		pre-eclampsia		thyroid problems	
diabetes		hemorrhaging		OTHER:	

Please indicate supplements taken during pregnancy: _____

Are you a single parent? (circle) yes no

Did you have adequate support or prenatal care during the pregnancy? (circle) yes no

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Birth History

Please check the box to indicate:

Vaginal		Forceps		Epidural / Drugs	
Cesarean Section		Suction		Vacuum Extract	

Length of labor: _____ (circle to indicate) pre term post term How many weeks late _____

Weight at birth: _____ Number of births: _____

Where did the birth occur? (circle one) home hospital birthing center

Did you use a midwife, doula or both? (circle one) midwife doula both midwife and doula

Was the birth traumatic on you, the baby or both? (circle one) mother baby both mother and baby

List complications during birth if present:

Neonatal History

Check the box next to the listed complication

neonatal jaundice		colic		rashes	
breathing problems		deformities (cleft palate)		OTHER:	

Growth and Development

Age child began to crawl _____ Age child began to teethe _____

Age child began to sit up _____ Age child began to speak (mama, dada) _____

Age child began to walk _____

How would you rate your child's health in their first year? (circle one) Poor Fair Good Excellent Unknown

Sleep: hours per day _____ hours per night: _____

Quality of Sleep (circle): easily aroused hard to wake nightmares sleep on stomach sleep on back

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Feeding History

Feeding (circle): breast fed bottle fed **Picky eaters** (circle): yes no

Most Common Eating Style (circle): home made (from scratch) home made (packaged food) eating out at restaurant

Length of breast / bottle feeding: _____ age when solid foods were introduced: _____

Feeding complications: _____

What foods were introduced before 6 months: _____

List the solid foods introduced: _____

Does your child have any dietary restrictions (religious, vegetarian / vegan etc.): _____

Please list any food cravings your child has _____

Please list any food aversions your child has _____

Describe a typical day's diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks/ Beverages: _____

Social History

Please describe the disposition of your child when interacting with other children, parents, and other caregivers:

Describe your child's behavior and performance at school:

Is your child physically active? yes no How much, how often? _____

How many hours of T.V per day? ____ How many hours on computer? ____ How many hours outside? ____

How many hours are spent reading with your child outside of school? ____

Schooling (circle): daycare preschool school

List the extracurricular activities your child is involved in or favorite activities:

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Family History:

Illness	Circle One	Family Member	Complications / Severity
Allergies	Yes No		
Asthma	Yes No		
Diabetes	Yes No		
Heart Disease	Yes No		
Cancer	Yes No		
Depression	Yes No		
Other mental illness	Yes No		
Kidney disease	Yes No		
Infertility	Yes No		
Post-partum depression	Yes No		
High Blood pressure	Yes No		
Other	Yes No		
Family History Unknown	Yes No		

Home Environment

Check the boxes that apply

Age of home: _____ Any recent renovations: _____ Upkeep of Home (circle): good bad

Lead Paint: ___ Asbestos: ___ Carpet: ___ Mildew: ___ Pets: ___ Smokers: _____

How is the home heated: _____

Home Location (check): Airport: ___ Industry: ___ Suburb: ___ City: ___ Highway: ___

Describe any known toxins or hazards the child is exposed to at home, daycare, hobbies outside environment etc.):

Describe the emotional climate of the child's home:

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Review of Systems

List conditions that involve the following systems:

SKIN (eg. eczema, psoriasis, hives, rashes)

HEAD (eg. headaches)

EYES (eg. itching, pain, infection, corrective lenses)

EARS (eg. wax, discharge, hearing impairment)

NOSE (eg. sinus problems, pain, nose bleeds)

MOUTH (eg. difficult dentition, cavities, loss of taste, problems swallowing)

NECK (eg. stiffness, tenderness, hoarseness, tonsillitis, swelling)

HEART (eg. rheumatic fever, murmurs, chest pain)

LUNGS (eg. cough, asthma, wheezing)

GASTROINTESTINAL (eg. vomiting, swallowing, diarrhea, constipation)

URINARY (eg. pain, increased frequency, blood)

MALE (eg. hernias, pain or masses in scrotum/testes)

FEMALE (eg. urgency, menstruation/menarche, discharge, pain or masses in ovaries/uterus)

MUSCLE AND SKELETON (eg. joint pain, stiffness, weakness, back pain, fractures)

NEUROLOGICAL (eg. seizures, paralysis, clumsiness, memory, vision changes, speech problems, sensation alteration)

Additional Information

If there is any other relevant information pertaining to your health that was not covered in this intake please state it below or on the back of the form: