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INTAKE FORM FOR CHILDREN

CHILD'S NAME ________________________**DATE OF BIRTH** _______________ **AGE** ____

CHILD'S ADDRESS _______________________**CITY**____________ **Postal Code**__________

PARENTS NAMES _____________________ _______________________

Parent's Cell#_______________________ ***Parent's E-mail**___________________________

CAREGIVER'S NAMES(S) (if appropriate) _______________________

Health Card _______________________________

PHONE NUMBER: (Home) _______________ **(Work)** __________ **(Other)** _____________

EMERGENCY CONTACT ___________________________ **PHONE** ____________________

FAMILY PHYSICIAN/PEDIATRICIAN ____

PHONE __________________ **HEALTH CARD #**_____________________________

SIBLINGS (Names and Ages)
____

How did you find out about our office?
____

If you have insurance coverage, please list name of insurer:
____

What treatments have been tried (please include both conventional and complementary)?
____

____

Please list any concerns that you have about your child's health:

1. ____ length of time_______________
2. ____ length of time_______________
3. ____ length of time_______________
4. ____ length of time_______________

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

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

Please list any supplements/herbs taken during pregnancy: ____

____

How would you describe the pregnancy? ____

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 ____**

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 HEALTH 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 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**			**Tonsillitis**		
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

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.

Food	Age of Introduction	Adverse Reaction

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?
____
___

____
___

How did you hear about our clinic?
____

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. I look forward to meeting with you in the near future.