

## Pediatric Intake Form

Child's Name: \_\_\_\_\_  
Child's Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M F  
Child's Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Grade Level: \_\_\_\_\_  
Today's Date: \_\_\_\_\_ Referred by: \_\_\_\_\_  
Who is filling out this form (name and relation): \_\_\_\_\_  
How did you hear about this clinic: \_\_\_\_\_

### **Contacts (in order of preference)**

Name and relation to child: \_\_\_\_\_  
Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_  
Phone: (cell or other) \_\_\_\_\_  
Address: \_\_\_\_\_

Name and relation to child: \_\_\_\_\_  
Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_  
Phone: (cell or other) \_\_\_\_\_  
Address: \_\_\_\_\_

Name and relation to child: \_\_\_\_\_  
Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_  
Phone: (cell or other) \_\_\_\_\_  
Address: \_\_\_\_\_

Whom does the child live with? \_\_\_\_\_

### **Child's Other Health Care Providers**

Provider's name: \_\_\_\_\_  
Designation (e.g., pediatrician, family physician, etc.): \_\_\_\_\_  
Address (if available): \_\_\_\_\_  
Phone: \_\_\_\_\_

Provider's name: \_\_\_\_\_  
Designation: \_\_\_\_\_  
Address (if available): \_\_\_\_\_  
Phone: \_\_\_\_\_

## Health Concerns

Please list your child's health concerns in order of importance.

1. Primary health concern: \_\_\_\_\_

At what age did this condition/illness begin: \_\_\_\_\_

What do you think might have caused this condition, and what other (possibly unrelated) events occurred around the time the condition began? \_\_\_\_\_

\_\_\_\_\_

What, if any, medications or supplements have been used to treat this condition and what was their effectiveness? \_\_\_\_\_

\_\_\_\_\_

Other health concerns:

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

## Prenatal Health and History

What was the health of the parents at the time of conception (please circle)?

Mother:      Poor    Fair    Good    Excellent    Unknown

Father:      Poor    Fair    Good    Excellent    Unknown

What was the health of the mother during pregnancy?

Poor    Fair    Good    Excellent    Unknown

What was the emotional state of the mother during pregnancy?

Poor    Fair    Good    Excellent    Unknown

How was the mother's diet during pregnancy?

Poor    Fair    Good    Excellent    Unknown

What was the mother's age at the time of the child's birth? \_\_\_\_\_

How many previous pregnancies and births did the mother have? \_\_\_\_\_

What was the mother's occupation during pregnancy? \_\_\_\_\_

Did the mother receive medical care during pregnancy? Yes No Unknown

Did the mother experience any of the following during pregnancy?

Bleeding                       High blood pressure                       Nausea                       Vomiting

Diabetes                       Thyroid problems                       Physical or emotional trauma

Other: \_\_\_\_\_

Did the mother use any of the following during pregnancy?

- Tobacco  Alcohol  Recreational drugs: \_\_\_\_\_
- Prescription medications: \_\_\_\_\_
- Over-the-counter medications: \_\_\_\_\_
- Vitamins and/or supplements: \_\_\_\_\_
- Other: \_\_\_\_\_

Were any of the following interventions used during pregnancy?

- Ultrasound  Amniocentesis  Chorionic villi sampling  Triple Screen
- Maternal serum screening  Other: \_\_\_\_\_

## **Birth History**

- Term length:  Pre-term (37 weeks or less): \_\_\_\_\_ weeks  
 Full-term (38-42 weeks): \_\_\_\_\_ weeks  
 Post-term (more than 42 weeks): \_\_\_\_\_ weeks

Location of birth:  Hospital  Home  Birthing Center  Other: \_\_\_\_\_

Type of birth:  Vaginal  C-section

Types of Intervention:

- Induced labour  Use of forceps  Epidural/anesthesia  Episiotomy
- Other: \_\_\_\_\_

Were there any complications during delivery (e.g., breech delivery)? \_\_\_\_\_  
\_\_\_\_\_

Length of labour: \_\_\_\_\_ Weight of infant at birth: \_\_\_\_\_  
APGAR score (0 to 10): 1 minute \_\_\_\_\_ 2 minutes \_\_\_\_\_ 5 minutes: \_\_\_\_\_

Did the child experience any of the following at or shortly after birth?

- Jaundice  Rashes  Seizures  Birth injuries: \_\_\_\_\_
- Infections: \_\_\_\_\_
- Difficulties with feeding: \_\_\_\_\_
- Birth defects: \_\_\_\_\_
- Other: \_\_\_\_\_

## **Dietary History**

How was your infant fed?

- Breast fed. How long? \_\_\_\_\_  Formula. Milk/Soy/Other: \_\_\_\_\_  
 Other: \_\_\_\_\_

Did your infant experience any reactions to the formula or breast milk? \_\_\_\_\_  
\_\_\_\_\_

What foods were introduced before 6 months? Please list the approximate month that each food was introduced, as well as any reactions that may have occurred.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What foods were introduced between 6 and 12 months? Were there any reactions to these foods?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did your child ever experience colic? Yes No  
If yes, how severe was the colic? Mild Moderate Severe

Does your child have any food allergies or intolerances? Please list.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe a typical day's diet for your child?

Breakfast \_\_\_\_\_  
Lunch \_\_\_\_\_  
Dinner \_\_\_\_\_  
Snacks \_\_\_\_\_  
Beverages (include total quantity) \_\_\_\_\_

Please describe your child's eating habits (e.g., good appetite, picky eater, etc.).

\_\_\_\_\_  
\_\_\_\_\_

## **Medical History**

Has your child ever experienced any of the following illnesses?

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Rubella         | <input type="checkbox"/> Mumps        |
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Chickenpox   |
| <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> Asthma       |
| <input type="checkbox"/> Scarlet Fever   | <input type="checkbox"/> Polio        |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other: _____ |

Has your child ever experienced any of the following conditions?

- |   |  |   |                                       |                                      |
|---|--|---|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Diaper rash              | <input type="checkbox"/> Cradle cap              | <input type="checkbox"/> Diarrhea       | <input type="checkbox"/> Constipation | <input type="checkbox"/> High fevers |
| <input type="checkbox"/> Heat or cold intolerance | <input type="checkbox"/> Trouble with bedwetting | <input type="checkbox"/> Frequent colds |                                       |                                      |
| <input type="checkbox"/> Ear infections           | How many and how often? _____                    |   |                                       |                                      |

Has your child received any of the following vaccinations?

- |                                   |  |                                     |                                |                             |                              |
|-----------------------------------|--|-------------------------------------|--------------------------------|-----------------------------|------------------------------|
| <input type="checkbox"/> DPT      | <input type="checkbox"/> MMR           | <input type="checkbox"/> HIB        | <input type="checkbox"/> Polio | <input type="checkbox"/> TB | <input type="checkbox"/> Flu |
| <input type="checkbox"/> Smallpox | <input type="checkbox"/> Pneumovaccine | <input type="checkbox"/> Chickenpox |                                |                             |                              |
| <input type="checkbox"/> Other:   | _____                                  |                                     |                                |                             |                              |

Did your child have any adverse reactions to, or chronic illness following vaccination? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child ever been hospitalized? Yes No If yes, for what and for how long? \_\_\_\_\_  
\_\_\_\_\_

Has your child ever had any significant physical or emotional traumas? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your child currently taking any medications or supplements? Please list.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have any known drug allergies? \_\_\_\_\_

## **Health and Development**

How was your child's health in the first year? Poor Fair Good Excellent Unknown  
How is your child's health now? Poor Fair Good Excellent Unknown

At what age did your child first:  
Sit up \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_ Talk \_\_\_\_\_

At what age did your child begin teething? \_\_\_\_\_ Were there any difficulties associated with it? \_\_\_\_\_

## **Sleep Patterns**

What time does your child usually go to bed? \_\_\_\_\_

What time does your child usually wake in the morning? \_\_\_\_\_

Does your child nap during the day? Yes No What time(s): \_\_\_\_\_

Does your child have nightmares? Yes No How often? \_\_\_\_\_

Does your child have any problems associated with sleeping (e.g., trouble falling asleep, trouble waking up, etc.)? \_\_\_\_\_

## **Social Patterns**

Is your child in: school daycare home care other: \_\_\_\_\_

How would you describe your child's behaviour at school? \_\_\_\_\_

How would you describe your child's behaviour at home? \_\_\_\_\_

What are your child's interests and favourite activities? \_\_\_\_\_

What, if any, recreational activities is your child involved in? \_\_\_\_\_

How would you describe your child's temperament/personality? Is there anything that you would want to change? \_\_\_\_\_

Does your child exercise regularly? Yes No How much and how often? \_\_\_\_\_

How much television does your child watch? \_\_\_\_\_ hours a day/week.

How often does your child read (not for school), or How often does someone read to your child?

Daily       Several times a week       Weekly       Less than weekly

## Family History

Indicate if a close relative (parent, grandparent, sibling) has had any of the following:

Condition	Relative	Condition	Relative
<input type="checkbox"/> Allergies		<input type="checkbox"/> Seizures	
<input type="checkbox"/> Anemia		<input type="checkbox"/> Stroke	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Eczema	
<input type="checkbox"/> Birth Defects		<input type="checkbox"/> Glaucoma	
<input type="checkbox"/> Bleeding Disorder		<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Cancer		<input type="checkbox"/> Psoriasis	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Depression	
<input type="checkbox"/> High Blood Pressure		<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Juvenile Arthritis		<input type="checkbox"/> Mental Illness	
<input type="checkbox"/> Other: _____	_____	<input type="checkbox"/> Other: _____	_____
_____	_____	_____	_____

I don't know the family medical history

Please fill in the following chart, based on the child's relatives:

Relation	Age (if living)	Died? At what age? Cause of Death?
Mother		
Father		
Brother(s)		
Sister(s)		
Maternal grandmother		
Maternal grandfather		
Paternal grandmother		
Paternal grandfather		

Do either of the parents have a chronic illness? Yes No Please describe. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Environment**

Are there any pets in the home? Yes No What type and how many? \_\_\_\_\_

\_\_\_\_\_

Does anyone in the child's household smoke? Yes No

How is the child's home heated? \_\_\_\_\_

Do you know of any toxins or other hazards that the child is regularly exposed to (home, other's work, hobbies, school, etc.)? Please describe. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How would you describe the emotional climate of the child's home? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have any known environmental or chemical sensitivities (e.g., perfumes, detergents, odors, soaps, etc.)? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Is there anything that you feel is important that has not been covered? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**The End!**