TRACY PALMER
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# Pediatric Intake Form

*Parent/Guardian please take the time to accurately complete this form. The information given is important in providing the best health care for your child. Please print clearly.*

Patient Name _____ Date _____

Age_____ Date of birth _____/_____/_____ (mm/dd/year) Gender _____

Height _____ Weight _____

**Parent/Guardian(s)** _____

Address _____City _____

Province _____ Postal Code _____

Phone number _____ (home) _____ (work)

_____ (cell) Email address _____

**Emergency Contact**:

Name _____ Relation _____ Phone _____

How did you hear about the office? Circle one: Internet/ Yellow pages/ Family/ GP referral/ Other, please specify _____

Name and Phone number of your family doctor: _____

_____

What is the main reason for your child's visit today?

_____

_____

If there is a specific condition, when did it start? _____

Is there a family history of this condition? Yes No

Please list any other health problems that are of concern to you for your child's well-being. List in order of importance:

1. _____ How long? _____
2. _____ How long? _____
3. _____ How long? _____

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Has your child been to any other health care providers for the above health concerns? Please list their contact information and what concerns they addressed.

| 1. | 2. | 3. |
|---|---|---|
| | | |
| (  ) | (  ) | (  ) |

How would you describe your child's general state of health? Excellent Good Fair Poor

Please list all of your child's past and/or current medical conditions, injuries, and hospitalizations, along with approximate dates:

_____

_____

_____

Does your child have any allergies (medications, environmental, foods, etc)? If so, please indicate allergen and reaction experienced:

_____

_____

Please list all current medicines that your child is taking (prescription, over-the-counter, vitamins, herbs, homeopathics, etc).

| Medicine (including brand, dose, frequency where applicable) | For how long? |
|---|---|
| | |
| | |
| | |
| | |
| | |

How many times has your child been treated with antibiotics? _____

Please indicate with an "X" which immunizations your child has had:

| | | | |
|---|---|---|---|
| | DPT (diphtheria, pertussis, tetanus) | | Polio |
| | Tetanus booster, when?_____ | | Haemophilus influenza B |
| | MMR (measles, mumps, rubella) | | "Flu" |
| | Hepatitis A | | Smallpox |
| | Hepatitis B | | Other_____ |

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Did your child experience any adverse reactions to these immunizations? If so, what were they?

_____

**Family History:**

Indicate if any immediate family member(s) are presently or have previously been affected by any of the following medical conditions:

| | Who? | | Who? |
|---|---|---|---|
| Severe allergies (anaphylaxis) | | Diabetes | |
| Heart Disease (heart attacks, strokes, arrhythmias) | | Thyroid Disease | |
| High Blood Pressure | | Asthma | |
| Cancer (specify type) | | Depression, Anxiety, and/or other mental illnesses | |
| Arthritis | | Suicidal tendencies | |
| Epilepsy | | Alcoholism/Drug Addiction | |
| Bed wetting | | Kidney Disease | |
| Learning disabilities | | Celiac | |
| Hyperactivity | | Other | |

_____ Check here if you do not know your child's family history

**Prenatal History:**

What was the mother's age at child's birth? _____

Did the mother experience any of the following during the pregnancy? Indicate with an "X" those that apply:

| | | | |
|---|---|---|---|
| | Diabetes | | Nausea |
| | Bleeding | | Vomiting |
| | High blood pressure | | Physical and/or emotional trauma |
| | Tobacco | | Alcohol |
| | Recreational drugs | | |

Other: _____

List any prescription drugs, over-the-counter medications, supplements, and/or vitamins the mother had taken during the pregnancy: _____

_____

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Mother's diet during pregnancy was: poor fair good excellent

Mother's emotional state during pregnancy was: stressed stable excellent

**Birth History:**

Term length: ☐ Full term ☐ Premature _____ weeks ☐ Late _____ weeks

How was the birth? Please list whether it was home/hospital, vaginal/C-section, any interventions (forceps, epidural, etc), and any complications _____

_____

Child's weight: _____ height: _____ length of labour: _____

Place an "X" beside any of the following that occurred at or soon after birth:

| | | | |
|---|---|---|---|
| | Birth defects | | Colic |
| | Birth injuries | | Rashes |
| | Jaundice | | Seizures |

Other:_____

**Diet:**

Initial feeding: ☐ Breast-fed How long? _____ ☐ Formula dairy/soy/other (circle one)

What solid foods were started before 6 months of age? _____

_____

**Lifestyle & Environment:**

Describe your child's general sleep pattern _____

_____

How would you describe your child's temperament? What about their behaviour and performance at school? _____

_____

Is your child currently in: daycare school home care other_____

Does your child exercise regularly? Yes No How much and what activities? _____

_____

Does anyone in the household currently smoke? Yes No

Emotional climate of the present household is: stressed stable excellent

Is there anything that you feel is important to your child's health that has not been covered by this form? Please explain

_____