Pediatric Intake Form

This form should take about 15 minutes to complete. Please answer the following questions regarding your child's health to the best of your ability. Thank you.

Name: _____ Age: _____ Birthdate: _____
Height: _____ Weight: _____
Mother's Name: _____ Age: _____
Father's Name: _____ Age: _____
Mother's Occupation: _____
Father's Occupation: _____
Child resides with _____ (mother, father, other)
Address: _____
Home Phone #: _____
Emergency Contact Name & Phone #: _____
Family Doctor/Pediatrician: _____
Phone #: _____

CHIEF HEALTH CONCERNS
Please list the main concerns regarding your child's health:
1. _____ 3. _____
2. _____ 4. _____
Has the child been treated for any of the conditions listed above?
(Please describe treatments/medications) _____
_____
_____
Were any of the treatments effective? Y/N
If yes, please list: _____

MOTHER'S PRENATAL HISTORY
Diet during pregnancy: _____
Supplements taken during pregnancy: _____
Drugs taken during pregnancy: _____
Mom's mental/emotional/physical health during pregnancy: (circle)
Excellent Good Fair Poor
If poor, please explain: _____
Complications during pregnancy: (please check all that apply)
__ Toxemia __ Diabetes __ Trauma
__ Hypertension __ Nausea __ Anemia
__ Vomiting __ Bleeding __ Other _____
__ Sexually transmitted infection (please list) _____

BIRTH HISTORY
Birth Environment: Hospital Home Birthing Clinic
Labour Duration: _____ __ Early __ Late __ Induced
Birth: __ Vaginal __ Caesarian __ Premature
Interventions: __ Forceps __ Epidural __ Suction
Birthing Complications: __ Meconium aspiration __ Breech
__ Jaundice __ Infection __ Other _____

NEONATAL HISTORY
APGAR Score: _____
Birth Defects: _____
Feeding: __ Breast How long? _____
__ Formula Type? _____
At what age? _____
How long? _____
Age when solids were first introduced? _____
What types of foods? _____
Developmental Milestones (please check all that apply):
__ Sitting Age: __
__ Crawling Age: __
__ Walking Age: __
__ Teething Age: __
__ Talking Age: __
Childhood Illnesses (please check all that apply):

__ Colic	__ Jaundice	__ Rash	__ Eczema
__ Mumps	__ Cradle cap	__ Whooping cough	
__ Measles	__ Asthma	__ Mononucleosis	
__ Tonsillitis	__ Pneumonia	__ Ear infections	
__ Strep throat	__ Other _____		

GENERAL HEALTH HISTORY
The child's overall health is:
Excellent Good Fair Poor (please explain):
_____
Please list any allergies/sensitivities (food, drug, environmental, etc.):
_____
_____
Please list medications (past & present):
_____
_____
_____
_____

Has your child ever experienced any of the following?

__ Abdominal pain
__ Antibiotic use
__ Bedwetting
__ Bloating
__ Blood in urine
__ Blurry vision
__ Breathing difficulty
__ Broken bones
__ Colds
__ Constipation
__Diarrhea
__ Dizziness
__ Fever
__ Flu
__ Frequent urination
__ Gas
__ Headaches
__ Hearing difficulties
__ Insomnia
__ Lethargy
__ Nausea
__ Nosebleeds
__ Pain on urination
__ Palpitations
__ Sore throat
__ Stiff neck
__ Surgery
__ Swollen glands
__ Thrush
__ Trauma
__ Vomiting
__ Weakness

Hospitalizations (when & for what): _____
_____
_____

Diet: Meat eater Vegetarian Vegan
Please list any foods not eaten for religious or other reasons:
_____

How is the child's appetite? Excellent Good Fair Poor

How is the child's sleep? (include how long, naps, restlessness, etc.)
_____
_____
Are vaccinations up to date? Y/N
Any adverse reactions to vaccinations? Y/N

SOCIAL HISTORY
How is the child's school performance/behaviour?
_____

Does the child have any known learning disabilities?
_____

Please list any extracurricular activities, hobbies or interests:
_____
_____
_____

FAMILY HISTORY

Relation	Age/Age at Death	Condition/Illness
Mother		
Father		
Brother(s)		
Sister(s)		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		

Additional Information:

_____

_____

_____

_____