CHILD INTAKE FORM (age 12 and under)

Patient:
Name: _____ Date: _____ Sex: M F
Birthdate: _____ Age: _____ Height: _____ Weight: _____
Address: _____ Apt.# _____
Number Street

_____
City Province Postal Code
Home# _____ Who does the child live with? _____

Name and Relationship of person filling out this form? _____

Parent/Guardian: ***Email Address***: _____
Name: _____ Relationship: _____
Address: _____ Apt. # _____
Number Street

_____
City Province Postal Code
Home# _____ Work# _____ Cell# _____

Additional Contact Person (in case of emergency)
Name: _____ Relationship: _____
Address: _____ Apt# _____
Number Street

_____
City Province Postal Code
Home# _____ Work# _____ Cell# _____

Family Physician
Name: _____ Telephone #: _____
Address: _____
Number Street City Province Postal Code

Were You **Referred**? _____ By Whom? _____

Other Health Practitioners
Name: _____ Telephone#: _____ Specialty: _____
Address: _____
Number Street City Province Postal Code

Home Information
Marital Status of Parents/Guardians?_____ Is the child from a stable home? _____
Number of Siblings? _____ Birth order of this child? _____
Was this child adopted? _____ Was this a planned child? _____

Primary Complaint
What is the Chief Concern today? _____
How long has this been a problem? _____
What were the prior treatments for this condition? _____
Results? _____

Secondary Concerns, in order of Importance:
1. _____ 2. _____ 3. _____

Medical History

The child's general state of health is (circle): Excellent Good Fair Poor

Screening tests the child has undergone (circle): Blood Urine Vision Hearing Other _____

List serious conditions and approximate dates of hospitalizations, surgeries, major illnesses:
_____
_____

List any allergies (ie. drugs, environmental, hayfever, etc.): _____
_____

List any medications the child is currently using (and for what conditions). Include prescription drugs, vitamin supplements, homeopathics, herbs, etc. :_____
_____
_____

List any past medications, and how long the child was using them: _____
_____
_____

How many times has the child been treated with antibiotics (approx.)? _____

Has the child had any of the following (circle):

Measles	Mumps	Chicken Pox	Rubella (German Measles)
Impetigo	Roseola	Scarlet Fever	Mononucleosis
Strep Throat	Ear Infections	Frequent Colds	Whooping Cough

Were any of these extremely severe? _____

Which Immunizations has the child received? (circle):

Tetanus booster	MMR (measles, mumps, rubella)	Polio
Hemophilus Influenza B	DPT (Diphtheria, pertussis, tetanus)	Flu
Hepatitis A	Hepatitis B	

Others: _____
Were there any adverse reactions? _____ If so, what? _____

<u>Prenatal History</u>

Circle any difficulties experienced during pregnancy with this child:

Emotional Trauma	Gestational Diabetes	Physical Trauma
Excess Bleeding	High Blood Pressure	Thyroid Problems
Excess Weight Gain	Nausea/Vomiting	Toxemia

Other: _____

Was the mother exposed to disease or toxins during pregnancy? Y N Unknown
If so, which ones? _____
Did the mother travel during pregnancy? _____ If so, where and for how long? _____
Did the mother work during pregnancy? _____ If so, how strenuously? _____ Until when? _____
Was there any alcohol, drug (prescription or recreational), tobacco, or supplement used during pregnancy with this child? Please describe. _____
Mother's diet during pregnancy?(circle) Excellent Good Fair Poor Unknown
Mother's health during pregnancy? (circle) Excellent Good Fair Poor Unknown
Did the mother receive prenatal care? _____

Neonatal History

Did the infant experience any of the following? (circle): Low weight Excess Weight Gain
Respiratory distress Anemia Rashes Colic Infections

Sleeping Habits

Please describe sleep: During first year of life _____ Now _____
How many hours of sleep per night?
Does the child need a nap? _____ At what time, and for how long? _____
What time is normal bedtime? _____

Does the child have trouble with (circle): Staying awake Falling Asleep Nightmares
Bedwetting Sleepwalking Sleeptalking Grinding Teeth Other Unusual Habits

Feeding History

Breastfed? _____ On Demand? _____ For how long? _____
Formula? _____ What kind? (circle): Soy Cow's Milk Other _____

Are there any dietary restrictions (religious, vegetarian, etc.)? _____

List the foods introduced before 6 months _____
_____

List foods introduced from 6 – 12 months _____
_____

Does the child have any food allergies or intolerances? _____
Does the child suffer from seasonal allergies? _____

Describe the child's **diet** on a typical day:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Drinks (type and quantity): _____

Bowel Movement Frequency? (circle) More than once/day Once/day Once/wk Less often
Urinary Frequency? _____ times/day. Anything unusual (colour/odour/amount)? _____

Behavioural/Emotional

How would you describe the child's temperament? Well-adjusted Separation Anxiety Shares
Performance Anxiety Independent Confident Outgoing Withdrawn Depressive
Plays well alone Plays well with others

List Fears: _____

Describe Relationships:
With Friends: _____
With Siblings: _____
With Other Relatives: _____
With Teachers: _____

Temper tantrums? Y N Aggressive? Y N How disciplined? _____

Interest/Activities/Hobbies _____

Parents' Health and Family History

Parents' age at conception: Mother _____ Father _____
Number of previous pregnancies? _____ Live births? _____
General medical health of parents at time of conception. Please circle:
Mother: Excellent Good Fair Poor Unknown
Father: Excellent Good Fair Poor Unknown

Please describe the current health of both parents:
Mother: Excellent Good Fair Poor Unknown
Father: Excellent Good Fair Poor Unknown
Do the parents smoke? Mother Y N Father Y N

Indicate if a Parent, Grandparent or Sibling has had any of these conditions:

	Who?		**Who?**
Allergies		Diabetes	
Asthma		Heart Disease	
Birth Defects		Juvenile Diabetes	
Cancer		Kidney Disease	

Other conditions: _____
Family History Unknown? _____

Birth History

Full-term? Y N Premature (___ weeks) Late (___ weeks)
Length of Labour? _____
Mother's emotional state during and after delivery? _____

Were there complications? _____

(Circle): Vaginal birth Induced Caesarian

Interventions?: Drugs Pitocin Suction Forceps Epidural Episiotomy

Height at birth _____ Weight at birth _____
Apgar Score _____ Head Circumference _____

Were any of the following experienced by the child during/after delivery?
Birth Defects Birth Injuries Seizures Jaundice Rashes
Other: _____
Where was the child delivered? Hospital Delivery Room Birthing Room Home Car
Other _____

Development

Describe the child's health in the 1st year: Excellent Good Fair Poor
Child's growth/size have been: Average Faster/Bigger than average Slower/Smaller than avg

	At What Age?		**At What Age?**
Rolling Over	_____	Talking	_____
Sitting Alone	_____	Toilet Training	_____
Crawling	_____	Teeth	_____
Walking	_____		

Describe the child's performance at school/intellectual ability _____

Review of Systems: (Please circle)

Head:	Rash	Dry Skin	Cradle Cap	Itchy Scalp	Fever		
Eyes:	Redness	Discharge	Rubbing	Lazy Eye			
Ears:	Pain	Rubbing	Discharge	Impaired Hearing			
Nose:	Congestion	Redness	Discharge	Allergy	Bleeding Nose		
Mouth:	Cold Sores	Teething	Drooling	Bad Breath	Cavities	Thirsty	
Skin:	Rash	Birthmark	Dryness	Eczema	Moles	Freckles	Itchiness
Neck/Throat:	Swollen glands		Sore throat	Difficulty Swallowing	Painful Movement		
Respiration:	Coughing	Hiccup	Congested lungs	Wheezing			
Cardiovasc:	Pale	Bluish Skin	Sweating	Palpitations	Varicose Veins		
Gastrointest:	Vomit	Food Reaction		Abd swelling	Diarrhea	Constipation	Bleeding
Genitourin:	Pain	Rash	Redness	Discharge	Blood in urine	Poor bladder control	
Musculosk:	Fracture		Sprain	Limp	Joint/Muscle Pain	Curved Spine	Food deformity
Neurologic:	Seizure		Tremor	Lethargic	Irritable	Jumpy	

List any countries the child has travelled to, and when:

_____

Is the child senstitive to (circle): Hot Cold Music Bright Lights

Child's Environment:

How much exercise does the child get? _____ hrs/day _____ hrs/week
Does the child play outside? _____
How much television does the child watch? _____ hrs/day _____ hrs/week
How much computer time/video games? _____ hrs/day _____ hrs/week
Does the child have a cell phone? _____ How much texting time? _____hrs/day _____ hrs/week
How much reading does the child do for pleasure (or how often is the child read to)? Please circle:
Daily Several times per week Weekly Monthly Rarely
Is the child most often at (circle): Home School Daycare Babysitter
Other_____
Are there any pets in the home? Y N. If so, what kind? _____
Any known allergies to pets? Y N
What type of heating is in the home? _____
Are there any hazards or toxins the child is exposed to? Please describe.

_____

Do you have any other concerns not previously mentioned?

_____

What are your goals for bringing this child in today?

_____

ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL.