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Child Intake Form

Name		Date (dd/mm/yr) / /
Birth Date (dd/mm/yr) / /	Age	Gender
Address		
City	Province	Postal Code
Caregiver's name and relation to child		Caregiver's name and relation to child
Caregiver's occupation		Caregiver's occupation
Caregiver's home number: ()		Caregiver's home number: ()
Caregiver's cell number: ()		Caregiver's cell number: ()
Caregiver's work number: ()		Caregiver's work number: ()
Family Doctor:		
Phone number: ()		
Would you like to receive our seasonal e-newsletter? Yes or No		
Email:		

With whom does the child live? _____

Please list other health care providers for your child:

1. _____ () _____
2. _____ () _____
3. _____ () _____

Please list the primary reason(s) for your child attending our clinic?

Medical History

Please check all that apply and indicate child's age at time of infection and how often:

<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Fifth's disease	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Frequent colds	<input type="checkbox"/> Polio	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> Hand, foot, mouth	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Strep throat
<input type="checkbox"/> Measles	<input type="checkbox"/> Rubella	<input type="checkbox"/> Ear infection
<input type="checkbox"/> Other		

Please list any major traumas, injuries, surgeries or accidents your child has sustained (ex. Car accidents, fractures, sprains, emotional traumas) with corresponding dates:

_____ Long term effects:

_____ Long term effects:

_____ Long term effects:

Does your child have any allergies or intolerances (medications, environment, foods, etc)?
Please list:

Please list all current and past medications, including all supplements that your child is taking:

Has your child ever been treated with antibiotics? Y or N
Please indicated how many times: _____

Nutrition

Does your child have any dietary restrictions (religious, vegetarian, vegan)? Y or N

<u>Breast fed</u>	<u>Formula fed</u>	<u>Solids</u>
How long?	Age started?	Age started?

Please list the first foods introduced: _____

Are there any foods that your child craves specifically? (chocolate, sweets, salty, sour, rich/fatty, breads, spicy) _____

Vaccinations

Please indicate what immunizations your child has had (please attach updated vaccination record):

<input type="checkbox"/> DPT (diphtheria, pertussis, tetanus)	<input type="checkbox"/> Haemophilus influenza	<input type="checkbox"/> Hepatitis A
<input type="checkbox"/> Tetanus booster: when?	<input type="checkbox"/> Flu	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> MMR	<input type="checkbox"/> Polio	<input type="checkbox"/> Rubella
<input type="checkbox"/> HPV	<input type="checkbox"/> Other	

Any adverse reactions to vaccinations (redness at site, crying, screaming, fever, etc): Y or N
 Please explain: _____

Does your get regular screening tests done by another doctor? (hearing, vision, blood tests, etc.)?
 Y or N If yes, please indicate: _____

Prenatal History

Was the child conceived naturally? Y or N
 If no please describe: _____

Did the mother experience any of the following during pregnancy?

<input type="checkbox"/> Bleeding	<input type="checkbox"/> Illness	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Other
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Nausea	<input type="checkbox"/> Thyroid problems	
<input type="checkbox"/> Emotional trauma	<input type="checkbox"/> Physical Trauma	<input type="checkbox"/> Vomitting	

Please list any vitamins or other supplements taken during pregnancy:

Please list any drugs, alcohol, cigarette smoking or medications taken during pregnancy:

Birth History

Term length: _____wks

Was the labour: Spontaneous? Induced? Duration of labour: _____ hrs

What type of delivery? Vaginal birth C-section Hospital Home birth

Were any interventions used? Epidural Episiotomy Forceps Suction

Were there any difficulties or complications with mother or baby? Y or N
If yes, please describe_____

Was mom Strept B positive? Y or N
If yes, were antibiotics used during birth? Y or N

Baby's birth Weight _____ Length_____ Apgar score _____

Health and Development

At what age did your child first:

Sit _____ Crawl _____ Walk _____ Talk _____ 1st tooth _____

Environment

Has your child ever been exposed to toxins or other hazards including second hand smoke, pesticides, herbicides, solvents, or sprays? If yes, please explain:

Do you live close to any of the following? Circle all that apply:

Airport / Dump / Highway / Industry / Power lines

How would you describe your home environment? Circle what applies:

Very stable / Stable / Stressful / Very stressful

Have you done any major renovations to your home recently? Y or N
Please describe: _____

Are there any pets in your household? Y or N

Personality and Behaviour

How much television does your child watch? _____ hrs a day/ week

How much time on the computer/video games? _____ hrs a day/week

What are your child's interests? _____

Family History

Please indicate if any close relatives have had any of the following (mother, father, siblings, aunts, uncles, etc):

	Father	Mother	Brothers	Sisters	Maternal		Paternal	
					G.mother	G.father	G.mother	G.father
Age (if living)								
Health G=good P=poor								
Allergies								
Asthma								
Heart Disease								
High blood pressure								
Cancer								
Diabetes								
Depression								
Other mental illness								
Drug abuse/alcoholism								
Osteoarthritis								
Rheumatoid arthritis								
Anemia								
Kidney Disease								
Other								

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