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Confidential infant/child Intake Form (Ages 0-13)

Date: _____ Date of Birth: _____

Preferred name: _____ Age: _____ Gender: **F M**

Name of person filling out form: _____ Relationship: _____

Address: _____

City: _____ Prov. _____ Postal Code: _____

Tel (home): _____ (work): _____ (cell): _____

email: _____

Parent's marriage status: _____

Personal Health Number: _____

Medical doctor: _____ Phone: _____

Emergency contact: _____ Relationship: _____ Phone: _____

How did you hear about this clinic? _____

_____

Current health status

What health concern(s) have brought you into this office? _____

_____

_____

Any recent changes? _____

_____

What have you tried so far and what have been the results? _____

_____

_____

_____

Please list any other health related concerns (incl. allergies). _____

_____

_____

_____

Height: _____

Smoke exposure? **Y N P** Amount: _____ Dates: _____

Alcohol exposure? **Y N P** Amount: _____ Dates: _____

Antibiotics Exposure? **Y N**