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PEDIATRIC INTAKE FORM (Birth- 5 years)

Patient's name: _____ Date of first visit: _____
Age: _____ Date of Birth: _____/_____/_____ Gender: female _____ male _____
Mother's name:_____ Father's name: _____
Address: _____City: _____ Prov: _____ Postal Code: _____
Phone # (home): (_____)_____ Parents # (work): (_____)_____ Parents e-mail address: _____
How did you hear about this clinic? _____
Name of Dr.'s Office/Hospital/Clinic where your child's health records are kept: _____
Care Card Number: _____
Reason for referral or presenting problems: _____
_____

MEDICATIONS	Now	Past		Now	Past
Aspirin	_____	_____	Antibiotics	_____	_____
Tylenol	_____	_____	Anti-histamine	_____	_____
Decongestant	_____	_____	Other	_____	_____
Ibuprofin	_____	_____	Allergies to medicines _____		

MEDICAL HISTORY

_____ Chicken pox _____ Scarlet fever _____ Tonsillitis, # of times_____
_____ Measles _____ Pneumonia _____ Ear infections, no. _____
_____ Mumps _____ Frequent colds _____ other (please list) _____
_____ Rubella _____ Rheumatic fever

Has your child had any of the following tests?	When	Where	Results
Electroencephalogram	.....		
Psychological evaluation	.....		
Hearing	.....		
Speech/Language	.....		

Injuries/Surgeries/Hospitalizations (please list): _____
_____

IMMUNIZATIONS

_____ Measles _____ Polio _____ MMR _____ Smallpox _____ Diphtheria
_____ Mumps _____ DPT _____ Tetanus _____ Influenza
Others (list) _____
Any adverse reactions? Y N What ? _____

FAMILY HISTORY

_____ Heart disease _____ Diabetes _____ Birth defects
_____ Hypertension _____ Arthritis _____ Tuberculosis
_____ Cancer _____ Allergies _____ Mental illness

PLEASE COMPLETE BOTH SIDES

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications? _____
_____
Mother's age at child's birth? _____
Mother's health during pregnancy?

_____ Bleeding _____ Physical or emotional trauma
_____ Nausea _____ Cigarettes, alcohol, drug consumption
_____ Illnesses _____ Medications
_____ Hypertension _____ Thyroid problems _____ Diabetes

BIRTH HISTORY

Term: Full _____ Premature _____ Late _____ Weight at birth_____
Length of labor _____ Complications? _____
Did your child have any of the following problems shortly after birth?
_____ Birth defects _____ Birth injuries _____ Blue baby

_____ Cerebral palsy _____ Seizures _____ Jaundice
_____ Colic _____ Fever _____ Rashes
Other (explain) _____
Child's sleep patterns (first year) _____
Food intolerances (if any) _____
Feeding: Breast fed? ____ how long? _____ Formula? ___ milk / soy _____
Age began solids _____ Which foods? _____
Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS (mark **Y** if current, **P** significant past symptom)

_____ Hives
_____ Eczema
_____ Bleeding gums
_____ Nose bleeds
_____ Acne
_____ High fevers
_____ Chronic rash
_____ Hearing loss
_____ Diarrhea
_____ Sore throats
_____ Headaches
_____ Frequent colds
_____ Wheezing
_____ Cough
_____ Burning of urine
_____ Frequent urination
_____ Heart murmur
_____ Vomiting spells
_____ Anemia
_____ Stomach aches
_____ Jaundice
_____ Easy bruising
_____ Flat feet
_____ Constipation
_____ Gas
_____ Bleeding tendency
_____ Joint pains
_____ Dizzy spells
_____ Bloody urine
_____ Cries easily
_____ Nervous
_____ Sleep problems
_____ Night sweats
_____ Sensitive to light
_____ Body/breath odor
_____ Motion/car sickness
_____ No appetite
_____ Nightmares
_____ Canker sores
_____ Unusual fears
_____ Excessive fatigue
_____ Hair loss

DIET

Please describe your child's typical daily diet:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
To Drink: _____

Thank you. We look forward to helping your child in any way we can.

9/06