



PEDIATRIC INTAKE FORM

PATIENT INFORMATION

First & Last Name: _____

Date of Birth: _____ Age: _____ Gender: M or F

Height: _____ Weight: _____

Names of Parents/ Guardians: _____

Address: _____

Town/City: _____ Province: _____ Postal Code: _____

Home Phone Number: _____

Work Phone number: _____

Email: _____

Emergency Contact.

Relationship: _____

Phone Number: _____

Patient's Primary Care Physician/Pediatrician:

Phone Number: _____ Address: _____

Person completing this form: _____

Relationship: _____

How did you hear about our clinic? _____

Were you referred to our office? Y or N If yes, by whom?

MEDICAL HISTORY

Main Medical Concern?

How long has you child been experiencing this?

Other health care providers consulted:

Treatments previously tried:

Please list any other Health Concerns with your child:

Please indicate if your child has experienced any of the following conditions currently {C} or in the past {P}.

Measles	C or P	Seizures	C or P
Chicken pox	C or P	Scarlet fever	C or P
Mononucleosis	C or P	Colic/gas/cramping	C or P
Mumps	C or P	Diarrhea	C or P
Ear infections	C or P	Digestive difficulties	C or P
Pneumonia	C or P	Constipation	C or P
Headaches	C or P	Frequent colds	C or P
ADD/ADHD	C or P	Coughing/wheezing	C or P
Rubella	C or P	Sinus problems	C or P
Asthma	C or P	Cold sores	C or P
Hives/rashes/eczema	C or P	Strep throat/tonsillitis	C or P
Allergies	C or P	Chronic runny nose	C or P
Hay fever	C or P	Anxiety	C or P
Temper tantrums	C or P	Bed wetting	C or P

VACCINATION HISTORY

Please check the box beside the vaccinations your child has received. Provide the appropriate dates.

- Diphtheria date _____
- Pertussis date _____
- Tetanus date _____
- Polio date _____
- Hemophilus Influenza B date _____
- Measles date _____
- Mumps date _____
- Rubella date _____
- Hepatitis B date _____
- Chicken Pox date _____

Did your child experience any adverse reactions to these vaccines? Y or N ?

If so, please indicate which ones? _____

Please list any current medications/supplements:

Please list any past medications/supplements:

Please list any allergies (environmental, food, medications):

Please list any past surgeries or hospitalizations, including dates and reason why:

Please give a typical day's diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

FAMILY HISTORY

Please indicate whether any family member has/had any of the following:

	Family Member		Family member
Cancer	_____	Autoimmune disease	_____
Heart disease	_____	Allergies/Asthma	_____
Diabetes	_____	Alcoholism/Addictions	_____
Tuberculosis	_____	Congenital conditions	_____
Depression/anxiety	_____	Genetic abnormalities	_____
Mental Illness	_____	Bleeding disorders	_____

PRENATAL HISTORY

Name of the midwife/Obstetrician/health care provider:

What was the health of the parents at the time of the conception?

Mother poor fair good excellent unknown

Father poor fair good excellent unknown

Please explain: _____
