pediatric intake form (infant - 12 years) ________

PLEASE COMPLETE THIS FORM AND BRING IT TO YOUR INITIAL APPOINTMENT (please print carefully)

Name: ____ Today's Date: ___________________________

Date of birth: (M/D/Y) ____________________________ Sex: q M q F

Child's Height: ___________________ Child's Weight: _____________________

Names of Parents/ Guardians: ____________________________________

Address: ____

____

Home phone: ____

Parents/Guardians work phone: ____________________________________

May we leave a message relating to your child's visits? q Yes q No

Name of person completing intake form: ___________________________

Relationship to patient: ____

Referred by: ____

Other health care providers you are seeing:

____

____

____

What are the child's health concerns, in order of importance?

1. ____

2. ____

3. ____

How long has the child been experiencing these symptoms and are there any factors you feel are associated to the onset and development of these symptoms?

____

____

____

root cause HEALTH & WELLNESS CLINIC

133 CHURCH ST., UNIT 41, ANTIGONISH, NS B2G 2E3 t: 902 735-3995 f: 902 735-3996

medical history ___

*Please note that all information supplied will be kept strictly confidential.

How would you describe your child's state of health? q Excellent q Good q Poor

How would you describe your child's physical development? q Advanced q Average q Poor

How would you describe your child's mental development? q Advanced q Average q Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates. ___

___

___

Does your child have any medical allergies? (antibiotics, medications, environmental, etc?)___

___

___

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc)

___

___

___

Approximately, how many times has your child been treated with antibiotics? ___

___

Does your child have any food allergies or intolerances? If so, please list.

___

___

___

Please indicate what immunizations your child had:

q DPT (diphtheria, pertussis, tetanus)

q Haemophilus influenza B

q Hepatitis A

q Tetanus booster; when? ___

q "Flu" Shot

q Hepatitis B

q MMR (measles, mumps, rubella)

q Polio

q Smallpox

Other: ___

Please indicate if any caused an adverse reaction: ___

___

___

___

Which of the following has your child experienced? Indicate "C" (current) or "P" (past):

_____	Ear infections	___	Skin conditions	____	Digestive complaints
_____	Growing pains	___	Easy bruising	____	Difficulty sleeping
_____	Allergies	___	Colic	____	Seizures
_____	Pneumonia	___	Asthma	____	Constipation
_____	Diarrhea	___	ADD/ADHD	____	Autism
_____	Learning disabilities	___	Sinus troubles	____	Headaches
_____	Nausea/Vomiting	___	Bed wetting	____	Chicken pox
_____	Mononucleosis	___	Impetigo	____	Measles
_____	Bronchitis	___	Frequent infections	____	Strep throat
_____	Thrush	___	Diaper rash	____	Urinary tract infections

Other (please specify): ____

____

____

Prenatal History:

Was your child premature? q Yes, # weeks: ____; q No

Medications during pregnancy: ____

Medications during labour/delivery: ____

How was the baby delivered? q Vaginal q C-section

Any complications during delivery? ____

Child's weight at birth: ____

Child's height at birth: ____

Was your child breastfed? q Yes, # of months. ______; q No – Formula fed - Type: ______________

When was your child introduced to solids (please indicate first foods): ______________________

____

____

____

Home life:

Please describe the child's home environment: ___________________________________

____

____

____

Has the child ever been under the care of a professional counsellor, psychologist, social worker or other therapist? Please explain ____

____

____

Please give a brief description of your child's personality: ____
____
____
____

Does your child exercise? q Yes q No

What type of exercise? ____
____
____

Environment:

Is the child exposed to tobacco smoke? q Y q N

Is your child frequently exposed to animals? q Y q N

Is your child regularly exposed to toxins or other hazards? Please describe: _________________________
____
____

Has your child ever traveled abroad? q Y q N

Location: ____________________________ Age at time of travel: _______________________________________

School Age Children:

Is your child attending public school or are they home-schooled? _____________________________________

At what age did your child start school? ____

What grade is your child currently in? ____

Does your child enjoy school? q Y q N

Has your child ever been diagnosed with a learning disability? q Y q N

If yes, please explain: ____
____
____

Describe your child's ability to interact socially with other children at school: _________________________
____
____

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