

DATE: _____

◆ Pediatric intake form ◆

D'Vine Living
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PEDIATRIC INTAKE FORM

Name: _____ Gender: _____ Age: _____ Date of birth: _____
Ethnic/ Religious Background: _____ Height: _____ Weight: _____
Address: _____ City: _____ Province: _____ Postal Code: _____
Phone (home): _____ (work): _____
Parent/ Legal Guardian Name: _____ Medical Doctor/Pediatrician: _____

PRIMARY HEALTH CONCERNS

(Please list in order of most importance)

1. _____
2. _____
3. _____
4. _____

Others: _____

How did these conditions develop? Are there any specific events (surgeries, drug reactions, accidents, food, etc.) that you can identify that caused or have aggravated these conditions? What has improved these conditions?

MEDICATIONS: (Past or current):

Prescribed medications:	Purpose	Dose	Side Effects
Over-the-counter medications:			
<i>Current</i>		<i>Past</i>	
Supplements (vitamins & minerals, herbs, homeopathics, other suppl.):			
<i>Current</i>		<i>Past</i>	

ALLERGIES or SENSITIVITIES

Allergy to:	Past	Current	Time of Onset
Medications			
Supplements			
Foods			
Environment			

PAST SURGERIES/ HOSPITALIZATIONS/INTERVENTIONS (ex. circumcision)

Surgery/hospitalization/ Interventions	Dates	Hospital/Clinic	Reason
1.			
2.			

3.			
4.			

ILLNESSES/ Review of Systems

(Please put an N if your child has the condition now, P for in the past, B for both)

Chicken Pox ___ Diphtheria ___ Rubella (german/3day) Measles (2 wk) ___ Mumps ___ Polio ___ Whooping
 Cough ___ Mononucleosis ___ Roseola ___ Rheumatic Fever ___ Scarlet Fever ___
 Cradle Cap ___ Headaches ___ Dizziness ___ Severe head injury ___ Seizures ___
 Vision Problems ___
 Frequent Runny Nose ___ Nose bleeds ___
 Recurring Ear Infections ___ Earaches ___
 Strep Throat ___ Tonsillitis ___
 Asthma ___ Bronchitis ___ Coughing/ Wheezing ___ Croup ___ Pneumonia ___ Pleurisy ___ Heart murmur
 ___ High Blood Pressure ___
 Frequent infections ___ Influenza ___ Fevers ___
 Acne ___ Ulcers ___ Hives/ Rashes ___ Herpes (oral) ___ Eczema ___
 Indigestion/ Gas ___ Constipation ___ Diarrhea ___ Colitis ___ Vomiting ___ Jaundice ___
 Bed wetting ___ Bladder infection ___
 Meningitis ___ Encephalitis ___ Cerebral Palsy ___ Paralysis ___ MS ___
 Anemia ___ Cancer ___ Diabetes ___ Hypoglycemia ___ Hypothyroid ___ Hyperthyroid ___
 Anxiety ___ Fears ___

If you have checked one of the above please fill out the following:

Condition:	How many times and when?	How long each time?

PRENATAL HISTORY – mother’s health during pregnancy

Has the child’s mother had any occurrences of miscarriages, stillborns or abortions? ___ Yes ___ No

If yes, describe: _____

Has the child’s mother ever had any difficulty conceiving (e.g. infertility, ectopic pregnancies):

If yes, describe: _____

Please place a check mark beside any of the following pregnancy complications, if they occurred:

Nausea ___ Vomiting ___ Hypertension ___ Diabetes ___ Pre-eclampsia ___ Bleeding ___

If you checked any of the above, describe the extent of the condition and what was done to treat it _____

Was the pregnancy planned? ___ Yes ___ No

Mother’s age at child’s birth: _____

Total children: ___ Genders: _____ Ages: _____

How many pounds did the mother gain during the pregnancy? _____

Describe mother’s diet during pregnancy, any food cravings?

What medications/supplements did the mother take during pregnancy?

Did mother exercise during pregnancy? How much and what type? _____

Did the mother smoke while pregnant? ___ Yes ___ No. Did the mother smoke before conception? ___ Yes ___ No

If yes, what amount: _____

Did the mother use drugs or alcohol? ___ Yes ___ No

If yes, type and amount: _____

While pregnant, did the mother have any medical or emotional difficulties? (e.g. surgery, hypertension, medication)

If yes, describe: _____

Where did the mother spend most of her time during pregnancy? _____ Describe the environmental conditions: _____

Did the mother travel during pregnancy? If yes where? _____

Did the mother have any infections (e.g. colds/flu/vaginal infections etc.) during pregnancy? If yes, what type? _____

PRENATAL HISTORY-Father's health before conception

Father's age at child's birth: _____

Did the father smoke prior to conception? ___ Yes ___ No; During the pregnancy? ___ Yes ___ No

If yes, what amount: _____

Did the father use drugs or alcohol preconception? ___ Yes ___ No

If yes, type and amount: _____

In what way was the father involved in the pregnancy? _____

PERINATAL/ NEONATAL HISTORY

Place of birth: Hospital ___ Home ___ Clinic ___ Other _____ Delivered by whom? _____

Length of pregnancy (weeks): _____

Was pregnancy easy? ___ Difficult? Describe _____

Was birth easy? ___ Difficult? Describe _____

Length of labor: _____ Induced ___ Caesarian ___ Interventions used (eg. forceps, vacuum, c-section)? _____

Length of hospitalization for mother: _____ Baby: _____

Describe any physical or emotional complications with the delivery: _____

Did breast feeding begin immediately? ___ Yes ___ No If no, when did it begin? _____

Please place a check mark beside any of the following conditions that applied to your baby at birth

Seizure ___	Respiratory distress	Jaundice ___	Problems with feeding _____
Vitamin K Administered _____	Antibiotic Eye Drops _____	Congenital Abnormalities _____	Respiratory Abnormalities _____

Describe any complications for the mother or the baby after the birth: _____

Baby's birth weight: _____ Baby's birth length: _____ Head circumference _____

APGAR Scores: _____

FEEDING/DIET HISTORY:

If breast-fed, how long? _____ Easy? ___ Difficult? _____

Approximate feeding schedule: _____

If formula fed, how long? _____ Combined with breast milk, if yes describe? _____

Types of formula and any adverse reactions? _____

Age solids foods introduced: _____ List foods and in what order they were introduced: _____

Please check off the following if there were any adverse reactions to any newly introduced foods:

Food Introduced	Colic	Bloating	Gas	Change in bowel movt's (diarrhea /constipation)	Nausea/Vomiting	Rashes
1.						
2.						
3.						

How many meals does your child generally eat each day? _____

How is your child's appetite in general? _____

Is your child a picky eater? ___ yes ___ no

List the primary foods included in your child's diet: _____

List the foods you exclude from your child's diet:

List any foods your child craves (include sweet, salty, fatty, etc. foods):

Amount of liquid your child drinks each day _____ Amt. plain water _____

Describe other types: _____

Are you satisfied with your child's diet? Why or why not?

Has your child lost or gained significant amounts of weight at any time? ___ Yes ___ No

If yes, explain: _____

Please place a check mark beside any of the following conditions that your child regularly experiences:

	Colic	Bloating	Gas	Change in bowel movt's (diarrhea /constipation)	Nausea/Vomiting	Rashes
1. When						
2. How often						
3. Why (if you know)						

Does your child have milk allergies? ___ Yes ___ No

IMMUNIZATION RECORD

Vaccination	Date	Adverse Reactions
Diphtheria, Tetanus, Pertussis (DPT)		
Oral Polio Vaccine (OPV)		
Measles, Mumps, Rubella (MMR)		
Hepatitis		
Hib		
Influenza		
Meningoc.		
Varivax		
Flu		

Has your child ever been out of the country? When? _____ Where? _____

DEVELOPMENTAL HISTORY

Please note the age at which the following behaviors took place:

Weaned: _____	Dry during day: _____	Dry during night: _____	Toilet trained: _____	Fed self: _____
Spoke words: _____	Spoke sentences: _____	Sat alone: _____	Crawled: _____	Took first steps: _____
Dressed self: _____	Tied shoe laces: _____	Rode two-wheeled bike: _____	First Teeth: _____	

Compared to others in the family, child's development was: Slow ___ Average ___ Fast ___

DENTAL HISTORY

Was the process of teething difficult for your child? ___ Yes ___ No. Describe _____

Has your child been to the dentist? ___ Yes ___ No

Describe any dental work done: _____

Describe your child's oral hygiene practice? _____

Is your child's toothpaste fluoridated? ___ Yes ___ No

VISION HISTORY

Has your child's eyes been checked? ___ Yes ___ No

Does your child wear glasses? ___ Yes ___ No

Describe any vision problems: _____

BOWEL/URINARY HABITS

Frequency of stool ____ times per day, ____ times per week

What does the stool look like? _____

Does your child have pain on passing stool? _____

Have you noticed any abnormalities in your child's stools? (colour changes, consistency, undigested foods) _____

Does your child experience any urinary symptoms? _____

SLEEP HISTORY

Does your child have trouble falling asleep? ____ Yes ____ No

How would you rate your child's sleep? (Scale of 1-10, Where 10 is excellent, 1 being very poor.) _____

Please check if your child experiences any of the following while sleeping:

Uninterrupted ____ Wakes often/ Restless ____ Nightmares ____ Wakes for reassurance ____

Wakes for food ____ Calm ____ Awakes well rested ____ Awakes tired/irritable ____ Night Sweats ____

Temperature of your child while sleeping is generally hot ____ cold ____ neither ____?

If nightmares, what is the theme? _____

What position does your child sleep in? _____

SOCIAL HISTORY/ HOME ENVIRONMENT

Who takes care of the child primarily? _____ Does the child have a babysitter/nanny? ____ Yes ____ No

Does the child go to daycare? ____ Yes ____ No.

How are problem behaviors, generally handled? _____

What are the family's favorite activities? _____

Does your child get along with other children ____ Yes ____ No Explain _____

Does your child get along with adults ____ Yes ____ No Explain _____

What does your child do with unstructured time? _____

How much time does your child spend in front of the TV/Computer? _____

What is your child's favourite book? _____

Does the child have a favourite toy/blanket? ____ Yes ____ No Describe _____

What extra activities is your child involved in? _____

How does your child keep his/her room? _____

Describe neighborhood (e.g. parks, other children, safety): _____

Describe your child's temperament: _____

Does she/he prefer to play alone or with others? _____

List any chemicals, fumes, dust, petsetc. that your child is repeatedly exposed to (including cigarette smoke, molds in the house): _____

Where does your child live? (City/country?) _____ (Apartment/Condo/Townhouse/house?) _____

Behavior/Emotions:

Please place a check mark beside any of the following behaviors/emotions that are typical for your child:

Affectionate ____ Generous ____ Shares ____ Confident ____ Listens to reason ____ Cooperative ____ Frustrated

easily ____ Irritable ____ Moody ____ Restless ____ Aggressive ____ Angry ____

Impulsive ____ Defiant ____ Selfish ____ Sad ____ Crying spells ____ Hopeless ____ Depression ____ Lazy ____

Shy/Timid ____ lack of self-confidence ____ Critical of self ____ Critical of others ____ Suspicious ____ Talks

back ____ Slow moving ____ Short attention span ____ Learning problems ____

Memory difficulty ____ Mental confusion ____ Makes many mistakes ____ Speech problems ____

Low self-esteem ____ Anxiety ____ Separation anxiety ____ Attachment to dolls ____ Avoids adults ____ Loner

____ likes company ____ Imaginary friends ____ Hallucinations ____ Nightmares ____

Dizziness ____ Stomachaches ____ Bedwetting ____ Soiling ____ Often sick ____ Tics/ Twitching ____

Blinking/ Jerking ____ Teeth grinding ____ Thumb sucking ____ Messy ____ Clumsy ____

Sensitive to noise ____ Organized ____ Careless/Reckless ____ Unsafe behaviors ____ Bullies/Threatens ____

Bizarre behavior ____ Sets fires ____ Hurts animals ____ Destructive ____ Steals ____ Suicidal threat ____

Suicidal attempts ____ Head banging ____ Sexual addiction ____ Cyber addiction ____

Drug dependence ____ Lies frequently ____

Anger:

What makes your child angry? _____

Does your child get angry often/easily? _____

Does your child experience uncontrollable rage? _____

Does your child have difficulty expressing anger? _____

Sadness:

What makes your child sad? _____

Does your child cry when sad? _____

Does your child cry often/easily? _____

Grief:

List major experiences of grief/loss in your child's life:

Fears:

What fears does your child have? _____

Influential Factors:*Listed below are factors that may or may not influence your child's state of being. Please put a B if the factor makes your child better, W if it makes your child worse, or leave blank if unaffected:*

Autumn ___ Winter ___ Spring ___ Summer ___
 Cold ___ Heat ___ Dampness ___ Storms ___ Wind ___ Sun ___ Moonlight ___
 Open-air ___ Confined (stuffy) air ___ Ocean Seashore ___ Mountains ___ Change of weather ___
 Upon rising ___ Morning ___ Afternoon ___ Evening ___ Night ___
 Touch ___ Being consoled ___ Left alone ___ Traveling ___ Physical exertion ___
 Other: _____

FAMILY HISTORY*(Please list ages and if deceased, what they died from and at what age)*

Mother's side	Mother	Father	Grandfather	Grandmother	Siblings
Age or If deceased: at what age?					
Cause of death?					
Father's side					
Age or If deceased: at what age?					
Cause of death?					

FAMILY HEALTH HISTORY*Please place a check mark beside the conditions that have occurred among the child's relatives**Note* Please also state who has/had the condition (ie. parents, siblings, aunts, uncles, grandparents):*

Allergies _____ Asthma _____ Anemia _____ Arthritis _____ Bleeding tendency _____ Blindness _____
 Cancer _____ Deafness _____ Diabetes _____ Eczema _____ Glaucoma _____ Gout _____
 Heart disease _____ High blood pressure _____ Hypothyroid _____
 Hyperthyroid _____ Kidney disease _____ Mental illness _____ Mental retardation _____ Migraines _____
 Multiple Sclerosis _____ Muscular Dystrophy _____ Nervousness _____ Perceptual motor
 disorder _____ Seizure/epilepsy _____ Stroke _____ Tuberculosis _____

Other (specify): _____

Adolescent INTAKE FORM

Name: _____ Gender: _____ Age: _____ Date of birth: _____
Ethnic/ Religious Background: _____ Height: _____ Weight: _____
Address: _____ City: _____ Province: _____ Postal Code: _____
Phone (home): _____ (work): _____
Parent/ Legal Guardian Name: _____ Medical Doctor _____

DEVELOPMENTAL HISTORY

Age of puberty onset: _____ Menstruation: _____ Breast development: _____
Voice change: _____ Pubic Hair Development _____
Any complications/ symptoms experienced at puberty?

Were there any issues that affected your development (e.g., physical/sexual abuse, inadequate nutrition, neglect, etc.): _____

Describe any symptoms that you experience before/during and/or after your period (e.g. breast tenderness, cramps, bloating, Nausea/Vomiting, fatigue, food cravings etc.)?

How long is your cycle? _____ What is the usual duration of your period? _____

SEXUALITY

Are you currently in an intimate relationship? _____ Yes _____ No For how long? _____

Are or have you ever been sexually active? _____ Yes _____ No

If yes, 1.what age did you become active and 2.what form of birth control are you using?

What is your sexual orientation? (e.g. Hetero/Homosexual) _____

Have you ever had an abortion? If yes when? _____

Have you ever been sexually abused? _____ yes _____ no

EATING HABITS

(Please write a 24-hour diet recall)

Breakfast: _____

Lunch: _____

Dinner: _____

Fluids: _____

SOCIAL HISTORY

Does you have a best friend? _____ Yes _____ No

How many close friends do you have? _____

Are your relationships strong or superficial? _____

What activities do you participate in regularly with your friends? _____

EDUCATION

Type of school: _____

Grade: _____

In special education? (e.g. gifted program) _____ Yes _____ No

If yes, describe: _____

Have you ever been held back in school? _____ Yes _____ No

If yes, describe: _____

What grades do you usually receive in school? _____

How do you feel about school? _____

What school activities do you become involved in? _____

INTERESTS/ ACTIVITIES

Describe special areas of interest or hobbies (e.g. art, reading, music, sports, organizations – scout, etc.)

What is your current stress level on a scale of 1 to 10? (10 being the worst stress you've ever had) _____

What is your current energy level on a scale of 1 to 10? (10 being the most energy you've ever had) _____

What are your future goals? _____

Do you have a part time job? _____ Yes _____ No

RECREATIONAL DRUGS

Does you use or have a problem with alcohol or drugs? _____ Yes _____ No

If yes, describe: _____

Do you smoke? _____ Yes _____ No; If yes how many cigarettes per day do you smoke? _____

