

DATE: \_\_\_\_\_

# ◆ Pediatric intake form ◆

D'Vine Living  
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Brantford, On  
N3R 2X3  
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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
<b>Over-the-counter medications:</b>			
<i>Current</i>		<i>Past</i>	
<b>Supplements (vitamins &amp; minerals, herbs, homeopathics, other suppl.):</b>			
<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? \_\_\_\_\_

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### **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?)

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### **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)*

<b>Mother's side</b>	Mother	Father	Grandfather	Grandmother	Siblings
Age or If deceased: at what age?					
Cause of death?					
<b>Father's side</b>					
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? \_\_\_\_\_