

PEDIATRIC INTAKE FORM

PATIENT INFORMATION

First & Last Name: _____

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

Height: _____ Weight: _____

Names of Parents/Guardian: _____

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? _____

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

MEDICAL HISTORY

Purpose of the visit to our office?

How long has your child been experiencing this?

Other health care providers consulted:

Treatments previously tried:

Please list any other health concerns with your child:

1. _____

2. _____

3. _____

4. _____

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.

- | | | |
|---|------------------------|------------|
| 1 | Diphtheria | date _____ |
| 1 | Pertussis | date _____ |
| 2 | Tetanus | date _____ |
| 3 | Polio | date _____ |
| 4 | Hemophilus Influenza B | date _____ |
| 5 | Measles | date _____ |
| 6 | Mumps | date _____ |
| 7 | Rubella | date _____ |
| 8 | Hepatitis B | date _____ |
| 9 | 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:

FAMILY HISTORY

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

Ailment	Family Member	Ailment	Family Member
Cancer		Autoimmune disease	
Heart Disease		Allergies	
Diabetes		Alcoholism	
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