Child Intake Form

Child's Name: _____

Date of Birth: _____ Gender: M F

Who is filling out the form (name and relation)?: _____

Contact Information (In order of Importance)

Name: _____ Relation: _____

Address: _____

Primary Phone (type): _____ Secondary Phone (type):_____

Email: _____

Name: _____ Relation: _____

Address: _____

Primary Phone (type): _____ Secondary Phone (type):_____

Email: _____

With whom does the child live? _____

Other current Health Care Providers

Name:_____ Name: _____ Name: _____

Specialty: _____ Specialty: _____ Specialty: _____

Phone: _____ Phone: _____ Phone: _____

Health Goals

What are your child's health concerns and goals, in order of importance?

1. _____ 3. _____

2. _____ 4. _____

Medical History

Please indicate any previous diagnoses not listed above

1._____

2._____

3._____

Please indicate any serious conditions, illnesses, or injuries, and any hospitalizations. Please include approximate dates.

1. _____ 2. _____

3._____ 4. _____

5._____ 6. _____

Does your child have any allergies (medicines, environmental, food, etc)

1._____

2._____

3._____

Please list all current medications (prescription and over-the-counter)

1._____ 2._____

3._____ 4._____

5._____ 6._____

Please list all passed medications

_____

Please list all current natural health products

1._____ 2._____

3._____ 4._____

5._____ 6._____

Please indicate which immunizations your child has had:

☐ DPT (diphtheria, pertussis, tetanus)
☐ Tetanus booster, When?
☐ MMR (measles, mumps, rubella)
☐ Haemophilus Influenza B
☐ Influenza ("Flu")
☐ Polio
☐ Hepatitis A
☐ Hepatitis B
☐ HPV
☐ Chicken Pox
☐ Small Pox

Other: _____

Please indicate if your child had any adverse reactions to the vaccines:

_____

_____

What screening tests has your child had (blood, hearing, vision, etc)

_____

Prenatal Health

Mother's age at child's birth: _____

Health of mother during pregnancy: Poor Fair Good Excellent Unknown

Mother's diet during pregnancy: Poor Fair Good Excellent Unknown

Did the mother receive prenatal care: Y N Unknown

Did the mother experience any of the following:

☐ Bleeding
☐ Diabetes
☐ High blood pressure
☐ Thyroid problems
☐ Nausea
☐ Vomiting
☐ Physical or emotional traum

Other : _____

Did the mother use any of the following during pregnancy:

Tobacco: _____ Alcohol: _____

Recreational drugs: _____

Prescription medications: _____

Over the counter medications: _____

Supplements: _____

Other: _____

Birth History

Term Length: Full Premature: _____days/wks Late: _____ days/wks

Length of Labour: _____ Weight at birth: _____

Location of Birth: Home Hospital Birth Centre

Any complications? _____

_____

Was the birth: Vaginal C-section Induced Forceps Anesthesia used

Did the child experience any of the following at or shortly after birth?

☐ Jaundice ☐ Seizures ☐ Birth defects

☐ Rashes ☐ Birth injuries

Other: _____

Diet

How was your infant fed? _____

Breast fed: how long?_____

Formula fed - Type: _____

Other:_____

When were solid foods introduced? _____ months

What was introduced before 6 months? _____

What was introduced between 6 and 12 months? _____

What was introduced after 12 months? _____

Development

At what age did your child first:

Sit up: _____ Walk: _____

Crawl: _____ Talk: _____

Describe your child's sleep pattern: _____

_____

Describe your child's temperament: _____

_____

How does your child interact with others? How does your child play with others?

_____

_____

How would you describe your child's behaviour and performance at school?

_____

_____

Family Health History

Please indicate if anyone in your family has experienced or is experiencing any of the following conditions and indicate your relation (i.e. mother, father, sibling, child, grandmother, grandfather)

Alcoholism: _____ Depression/anxiety: _____

Allergies (specify): _____ High blood pressure: _____

Arthritis: _____ Heart Disease: _____

Asthma: _____ Stroke: _____

Cancer (specify): _____ Osteoporosis: _____

Diabetes: _____

Do either parents have a chronic illness? Y N Please describe: _____

Environment

Is the child in school: _____ grade daycare home care other: _____

What are your child's favourite activities? _____

Does your child exercise regularly? Y N

How much? _____ How often? _____

What activities? _____

How much television does your child watch per week? _____

How often does your child read or is read to?

Daily Several times per week Weekly Less than weekly

Does anyone in the household smoke? Y N

Are there animals in the home? Y N Type: _____