



## Pediatric Intake Form

Name \_\_\_\_\_ D.O.B \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Gender \_\_\_\_\_ Height (cm): \_\_\_\_\_ Weight (lbs.): \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Family Physicians Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Emergency Contact Numbers (other than parent/guardian) \_\_\_\_\_

\_\_\_\_\_

### Chief Complaint(s)/Concern(s)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Family History

Any major health concerns in the family (biological parents, grandparents, and family)?  
i.e. Heart disease, Diabetes, etc.

\_\_\_\_\_

\_\_\_\_\_

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### Prenatal History

1. Age of mother and father at onset of pregnancy? \_\_\_\_\_
2. Is/was this your first pregnancy? (if not please indicate number if pregnancies)  
\_\_\_\_\_
3. Any prior miscarriage(s)? \_\_\_\_\_
4. Any history of infertility? \_\_\_\_\_
5. Any fertility medications used?  
(indicate) \_\_\_\_\_
6. Amount of weight gained during pregnancy? \_\_\_\_\_
7. Any symptoms experienced during pregnancy such as nausea, vomiting, and food  
cravings etc. \_\_\_\_\_
8. Any infections, illnesses or complications during pregnancy? (if yes, please specify) If  
so, how were they treated?  
\_\_\_\_\_  
\_\_\_\_\_
9. Travel history (Did you travel during or anytime before your pregnancy, if yes, please  
specify)  
\_\_\_\_\_  
\_\_\_\_\_
10. How was your diet and appetite during pregnancy? Please list the typical foods  
consumed during your pregnancy.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
11. Were you ever exposed to the following during your pregnancy?

<b>Alcohol</b>	
<b>Recreational Drugs</b>	
<b>Smoke</b>	
<b>Stress, Trauma</b>	
<b>Medications (if so please specify)</b>	
<b>Supplements</b>	
<b>Heavy Metal (paint chips etc)</b>	



**Natal History**

**Duration of pregnancy**

Full term \_\_\_\_\_ Premature (if so how many weeks) \_\_\_\_\_ Late \_\_\_\_\_

Birth Weight (lbs.) \_\_\_\_\_ Birth Length (cm) \_\_\_\_\_

Head Circumference (cm) \_\_\_\_\_

How long was the labor? \_\_\_\_\_

Where there any medications administered prior to delivery? (If so, specify) \_\_\_\_\_

**Type of delivery**

Vaginal	
C-section	
Suction	
Forceps	
Induced	

Any complication experienced? (If so, please specify)  
 \_\_\_\_\_  
 \_\_\_\_\_

**Nutrition and Feeding**

Was the child breastfed? (If so, for how long) \_\_\_\_\_

Formula Fed? \_\_\_\_\_ How long \_\_\_\_\_ Which Formula \_\_\_\_\_

Any reaction or difficulty feeding? \_\_\_\_\_

What was the time of food introduction and what type? (Please indicate time of introduction)

Time of Introduction ( month)	Type of food

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Does your child have any food allergy(s) and/or intolerance (s)? (Please indicate)

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What are their eating habits like? \_\_\_\_\_

Dietary Restrictions \_\_\_\_\_

Supplements? \_\_\_\_\_

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### Medical History

### Vaccination Record

Type	Date	Reactions
DPT		
HiB		
MMR		
Polio		
Hepatitis B		
Varivax		

Any major accident(s) and/or hospitalization(s)? (Please indicate date and what for)

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Does your child have any medical conditions? If so, are they currently on any medication(s) for it?

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### Childhood Illnesses

Type	Date
Chicken pox	
Measles	
Fifth Disease	
Croup	
Whooping cough	

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Ear infections	
Other	

### Dental History

Is your child currently seeing a dentist? \_\_\_\_\_

Name of dentist \_\_\_\_\_ Phone Number \_\_\_\_\_  
Address \_\_\_\_\_

Is your child teething currently? \_\_\_\_\_ And when did it  
start \_\_\_\_\_

When did their first teeth appear?  
\_\_\_\_\_

How many teeth do they currently  
have \_\_\_\_\_?

Any cavities? (If so, how many and what type of filling)  
\_\_\_\_\_

Any bleeding gums or other dental concerns?  
\_\_\_\_\_

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### Developmental Milestones

Development	Age
Smile	
Sits with support	
Sits up (independent)	
Crawled	
Walked	
Talked	
Teething	
Potty trained	

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**Social History**

With whom does your child live with?

\_\_\_\_\_

What is the living environment like? \_\_\_\_\_

How is the home heated? \_\_\_\_\_

Water source (well, tap, filtered etc) \_\_\_\_\_

**Is your child exposed to the following?**

Tobacco	
Heavy metals	
Alcohol	
Molds, fungus	
Chemicals	
Pets	

Is violence a concern in the home? \_\_\_\_\_

Is your child currently in school? \_\_\_\_\_ Day Care \_\_\_\_\_ Home \_\_\_\_\_

What grade is your child in? \_\_\_\_\_

Any learning difficulties? (If so, please specify) \_\_\_\_\_  
\_\_\_\_\_

Extracurricular activities? (Please list)

\_\_\_\_\_  
\_\_\_\_\_

Do they have playmates? \_\_\_\_\_

How is your child's sleep? \_\_\_\_\_ How many hours? \_\_\_\_\_

Naps? \_\_\_\_\_ How is their energy level? \_\_\_\_\_

How is their activity level? \_\_\_\_\_

How is temperament? \_\_\_\_\_

Average number of hours of TV and/or computer exposure? \_\_\_\_\_



**Adolescence**

Are you in school? \_\_\_\_\_ Current grade \_\_\_\_\_

What extracurricular activities do you participate in?

\_\_\_\_\_

Tobacco use? \_\_\_\_\_ Frequency \_\_\_\_\_ Amount \_\_\_\_\_

Alcohol use? \_\_\_\_\_ Frequency \_\_\_\_\_ Amount \_\_\_\_\_

Recreational drug use? If so, please list type used \_\_\_\_\_

\_\_\_\_\_

Frequency \_\_\_\_\_ Amount \_\_\_\_\_

Are you sexually active? \_\_\_\_\_ Are you practicing safe sex? \_\_\_\_\_

Describe your home environment.

\_\_\_\_\_

\_\_\_\_\_

What is your sexual identity? \_\_\_\_\_

Have you ever experienced abuse in any form? \_\_\_\_\_

24 hour diet recall (please list foods you have eaten in the past 24 hours)

Breakfast	Lunch	Supper	Snacks	Drinks

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**Females (complete this section)**

Age of first menarche (period) \_\_\_\_\_

Duration of cycle \_\_\_\_\_ Duration of flow \_\_\_\_\_

Last known menstrual period \_\_\_\_\_

Tampons? \_\_\_\_\_ Pads? \_\_\_\_\_ Other, indicate \_\_\_\_\_

Average number used per day during period (tampons, pads, etc) \_\_\_\_\_

Characterize your period (circle):      heavy              light

Do you experience any PMS (such as breast tenderness, cramps, and irritability)?

\_\_\_\_\_

\_\_\_\_\_

Do you notice clotting?

\_\_\_\_\_

Are you on the birth control pill? \_\_\_\_\_ Specify brand \_\_\_\_\_

How long have you been on it? \_\_\_\_\_

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**Consent**

I \_\_\_\_\_ hereby acknowledge that the above information is accurate  
Parent/guardian

to the best of my knowledge, and I hereby consent to treatment for my child  
\_\_\_\_\_.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature