CHILD INTAKE FORM

Please note that the information provided is considered confidential and is for the use of the practitioner only.

Date:

Name:
Date of birth:
Sex:
Height:
Weight:

Parent/ Guardian
Name:
Address:
Phone Number:
email:

Family Doctor
Name:
Address:
Phone Number:
email:

CHIEF CONCERN(S)

Please list health concerns, any diagnoses, any previous treatments and outcomes of those treatments.

MEDICAL HISTORY

What is the description of your child's health?

Please indicate any hospitalizations/surgeries- when and why?

Please check if child was diagnosed with the following:

rubella	roseola	impetigo	measles	scarlet fever	mononucleosis
chicken pox	mumps	strep throat	ear infections	whooping cough	allergies

Please check the immunizations given.

diphtheria, pertussis, tetanus	Haemophilus influenza B	Hepatitis A
measles, mumps, rubella	Polio	Hepatitis B
tetanus booster	Flu vaccine	

Current list of medications and supplements:

PRENATAL HEALTH

Please check if the mother experienced any of the following during pregnancy

gestational diabetes	thyroid conditions	nausea/vomiting	emotional trauma
physical trauma	infections	high blood pressure	toxemia
bleeding	prescription drugs	recreational drugs	supplements
alcohol	tobacco	other	

How was the health of the mother during pregnancy?

What were the parents' ages at time of conception?

How was the stability of the home at time of conception?

Any other comments?

BIRTH HISTORY

Home or hospital birth?

Length of labour:

Interventions during labour:

Term length: full, premature, late
Weight:
Height:
Head circumference:
APGAR score:

Any complications during labour ?

Any complications post partum?

NEONATAL HISTORY

congenital abnormalities	jaundice	respiratory distress
poor feeding	birth injuries	infections
seizures	anemia	rashes
colic	other	

DIET

How was your infant fed?

- breast fed - how long?
- formula - milk/soy/other
- nut milks
- what is the current diet like?

GENERAL INFORMATION

SLEEPING HABITS:

- during first year of life:
- at present:
- any napping?:
- trouble staying awake or falling asleep?:
- bedwetting?:
- bedtime and waking time:
- sleep position:

BEHABIOUR AND EMOTIONAL HISTORY:

- at school:
- at home:
- relationships with friends, family, siblings:
- interests and/or activities:
- fears:
- pets:

MILESTONES – AGE:

- sitting:
- standing:
- first word:
- rolling over:
- first tooth:
- lifting head:
- walking:
- self-feeding:

REVIEW OF SYSTEMS

cradle cap	eczema	allergies
asthma	diaper rash	thrush
tonsilitis	enlarged adenoids	drooling
dental caries	ear infections	runny nose
bleeding gums	cravings	bloody nose
thirst	aversions	diarrhea
growing pains	broken bones	constipation
flat feet	temperature: hot or chilly	perspiration
activity level	motion sickness	fears
colic	warts	lice
intestinal parasites	tinea	scabies

Additional comments by parent/guardian pertaining to the intake form: