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Child Intake

Child's Name ________________________________Date of Birth ________________ Sex M F

Who is filling out this form? Name _____________________ Relationship _________________

Referred by ____

Contacts (in order of preference)

1. Name _______________________________________ Phone (H) __________________________

   Address ____________________________________ (W) _________________________

   ____

Relationship to Child ____

2. Name _______________________________________ Phone (H) __________________________

   Address ____________________________________ (W) _________________________

   ____

Relationship to Child ____

Whom does the child live with? ____

Other health care providers

1. ________________________ 2. ________________________ 3.________________________

________________________ ________________________ ________________________

Phone #___________________ Phone #___________________ Phone #___________________

What are your child's health concerns, in order of importance:

1. ____

2. ____

3. ____

4. ____

Child's Medical History
Please indicate any serious conditions, illness or injuries, and any hospitalizations, along with approximate dates:

____
____
____
____

Which of the following diseases has your child had?

☐Rubella (German measles) ☐Roseola ☐Impetigo
☐Measles ☐Scarlet Fever ☐Mononucleosis
☐Chicken pox ☐Strep throat ☐Ear Infections
☐Whooping cough ☐Mumps

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

____
____

Please list all CURRENT medication (Prescription, over-the-counter, vitamins, herbs, homeopathics, etc.).

____
____
____
____

Please list all PAST prescription medications.

____
____
____
____

How many times has your child been treated with ANTIBIOTICS? ________________________

Which of the following immunizations has your child had?

☐DPP(diphtheria, pertussis, tetanus) ☐Haemophius influenza ☐Hepatitis B
☐Tetanus booster: when? _____ ☐"Flu" ☐Hepatitis A
☐MMR(measles, mumps, rubella) ☐Polio ☐Chicken Pox
☐Other ________________________

Please indicate if any of the above have caused an adverse reaction:

____
____

Has your child had any screening test (i.e. blood, hearing, vision)? ☐Yes ☐No
If yes please list:

____
____

Child's Diet

How was your infant fed?

☐Breast-fed: how long? _________ ☐Formula: ☐Milk ☐Soy ☐Other

☐Other: ________________________

Where foods introduce before 6 months? ☐Yes ☐No

If yes please list:

____

____

What foods were introduced between 6-12 months?

____

____

____

Did your child ever experience colic? ☐Yes ☐No

Was it? ☐Mild ☐Moderate ☐Severe

Does your child have any food allergies or intolerances? ☐Yes ☐No

If yes please list:

____

____

Does your child have any dietary restrictions (i.e. religious, vegetarian/vegan)? ☐Yes ☐No

If yes please list:

____

____

Describe a typical day's diet for your child

Breakfast ____________________________________

Lunch ____________________________________

Dinner ____________________________________

Snacks __________________________

Beverages:

Type? ____________________________

How many? ______________________

Health and Development

How was your child's health in the first year? ☐Poor ☐Fair ☐Good ☐Excellent ☐Unknown

At what age did your child first:

Sit up _________ Crawl _________ Walk _________ Talk _________

Describe your child's sleep pattern:

____

Describe your child's temperament:

____

Describe your child's behaviour and performance at school:

____

____

Prenatal Health

What was the health of the parents at conception?

Mother: ☐Poor ☐Fair ☐Good ☐Excellent ☐Unknown

Father: ☐Poor ☐Fair ☐Good ☐Excellent ☐Unknown

What was the health of the mother during the pregnancy?

☐Poor ☐Fair ☐Good ☐Excellent ☐Unknown

How was the mother's diet during pregnancy ?

☐Poor ☐Fair ☐Good ☐Excellent ☐Unknown

What was the mother's age at the time of this child's birth? ______________________

Did the mother receive prenatal medical care? ☐Yes ☐No ☐Unknown

Did the mother experience any of the following during the pregnancy:

☐Bleeding ☐High Blood Pressure ☐Nausea ☐Vomiting

☐Diabetes ☐Thyroid Problems ☐Physical Trauma ☐Emotional trauma

☐Other:____

Did the mother use any of the following substances during the pregnancy?

☐Recreational drugs: Type? ____

☐Prescription Medications: List? ____

☐Over-the-counter Medications: List? ____

☐Supplements: List?____

☐Tobacco ☐Alcohol ☐Other: ______________________________________

Birth History

Term Length: ☐Full ☐Premature: _________wks. ☐Late: _________wks.

Length of labour: ___________________ Child's weight at birth: ________________

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

Where they're any complications? ☐Yes ☐No

If yes explain?

____

____

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

☐Jaundice ☐Rashes ☐Seizures

☐Birth injuries: _______________________ ☐Birth defects:____________________________

☐Other:______________________________

Family History

Do you know the family medical history? ☐Yes ☐No

Indicate if a close relatives (i.e. parent, sibling) has had any of the following:

Symptoms	Who & Relationship	Symptoms	Who & Relationship
Allergies		Birth defects	
Asthma		Juvenile arthritis	
Diabetes		Other	
Kidney disease			

Do either of the parents have a chronic illness? ☐Yes ☐No
If yes please describe.

____

____

Child's Environment

Is the child in? ☐School ☐Daycare ☐Home care ☐Other

What are the child's favourite activities?

____

____

Does the child exercise regularly? ☐Yes ☐No
How much? ____________________
How often? ____________________

How much television doe your child watch? ____________ hrs. per day/week

How often does your child read, or is read to (not for school)?
☐Daily ☐Several times a week ☐Weekly ☐Less than weekly ☐Never

Does anyone in the child's household smoke? ☐Yes ☐No

Are there any animals in the home? ☐Yes ☐No
What kind? ____

How is the child's home heated? ________________________________

Do you know of any toxins or hazards the child is regularly exposed to (home, school, hobbies)? Please describe:

____

____

How would you describe the emotional climate of the child's home?

____

____