

## Pediatric and Teenager Patient Intake Form

### Personal Information

Name _____	Date _____
Date of birth _____	Age _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address _____	City _____
Province _____	Postal Code _____
Phone: Home _____	Work _____ Other _____
Email _____	May we leave messages relating to your visits? <input type="checkbox"/> Yes <input type="checkbox"/> No
Who is filling out this form (name and relation)? _____	
Emergency contact:	
Name _____	Relation _____ Phone _____
How did you hear about our clinic? _____	
Other health care providers (family physician, specialists, complementary and alternative therapy):	
1. _____	2. _____ 3. _____
Ph: _____	Ph: _____ Ph: _____
What are the main health concerns that you would like addressed:	
1. _____	
2. _____	
3. _____	
4. _____	
5. _____	

### Medical history

How would you describe your general state of health?  Excellent  Good  Fair  Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates.

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Do you have any allergies (medicines, environmental, etc.)?

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Please list all current medications, including dosages, duration of use and why you are taking them.

Medication	Dose	Duration	Condition Treating

Please list all natural health products you are taking (vitamins, supplements, herbs, homeopathics).

Natural Health Product	Dose	Duration	Condition Treating

Please list past prescription medications.

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How frequently are you treated with antibiotics? \_\_\_\_\_

Do you regularly use any of the following?

Aspirin  Laxatives  Antacids  Diet pills  Birth control pills  Implants  Injections

Alcohol—how much/ day or week \_\_\_\_\_

Tobacco—form and amount/day \_\_\_\_\_

Caffeine—form and amount/day \_\_\_\_\_

Recreational drugs—what and how often \_\_\_\_\_

Please indicate which immunizations you have had:

DPT (diphtheria, pertussis, tetanus)  Haemophilus influenza B  Hepatitis A

Tetanus booster; when? \_\_\_\_\_  "Flu"  Hepatitis B

MMR (measles, mumps, rubella)  Polio  Smallpox

Other \_\_\_\_\_

Please indicate if any caused adverse reactions: \_\_\_\_\_

Please indicate with a check mark if you have experienced any of the following conditions:

	Currently	Past		Currently	Past
Acne			Epilepsy/Seizure		
Allergies			Fatigue		
Anemia			Frequent Infections		
Asthma			Headache		
Bed Wetting			Heart Murmur		
Birth Defects			High Fever		
Colic			Hyperactivity		
Constipation			Insomnia		
Cough/Wheeze			Jaundice		
Cradle Cap			Learning Disorder		
Depression			Moodiness		
Diarrhea			Stuffy Nose		
Dizzy Spells			Thrush		
Earaches/Ear Infection			Vomiting		
Eczema			Other		

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)?  Yes  No

When were your most recent tests performed? \_\_\_\_\_

### Prenatal and Infant History

Mother's health during pregnancy:

Age of Mother and Father	
Trauma/Injury	
Alcohol Consumption/Drugs/Smoking	
Bleeding	
Stress	
Toxemia	

Nausea	
High Blood Pressure	
Illness	
X-rays	
Diabetes	
Medications	

**Pregnancy Term:**

Premature	
Full birth weight	
Easy/Difficult Pregnancy	
C-Section	
Breech	

**Feeding of Infant**

Breast Fed? For how long?	
Milk? What type and how long?	
Formula fed? What type and how long?	
Age solid food introduced	
What foods were introduced first?	

**Diet**

Do you have any food allergies or intolerances? Please list.

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Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

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**Family history**

Indicate if a close relative (parent, child, sibling) has had any of the following:

	Who?		Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug abuse/alcoholism	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes			

I don't know my family medical history

## Environment

What grade are you in? \_\_\_\_\_

Hobbies \_\_\_\_\_

Do you exercise regularly?  Yes  No

What do you do for exercise, for what duration and how often?

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

Are you exposed to significant tobacco smoke (at work, home, etc.)?  Yes  No

Are you frequently exposed to animals (work, pets, etc.)?  Yes  No

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.

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

How would you describe the emotional climate of your home?

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

How would you rate your stress levels?

Overwhelming  High  Moderate  Low  Minimal

Is there anything that you feel is important that has not been covered?

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

Are there any other services you would like to learn more about?

- Massage Therapy/Shiatsu
- Psychotherapy
- Chiropractic