Child Intake Form

PLEASE COMPLETE AND BRING THIS FORM WITH YOU TO YOUR CHILD'S FIRST APPOINTMENT

Child's Name_____ Date of birth _____ Sex M F Date _____

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 you child's health concerns, in order of importance:

1. _____
2. _____
3. _____
4. _____

Child's Medical History

How would you describe your child's general state of health? EXCELLENT GOOD FAIR POOR

Please indicate any serious conditions, illnesses 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 medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

_____

_____

_____

_____

Please list PAST prescription medications.

_____

_____

_____

_____

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

Which of the following immunizations has your child had?

DPT (diptheria, pertussis, tetanus)	Haemophilus influenza b	Hepatitis B
Tetanus booster; when? _____	"Flu"	Hepatitis A
MMR (measles, mumps, rubella)	Polio	Chicken Pox
Other_____		

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

_____

_____

Has your child had any screening test (ie. Blood, hearing, vision)? YES NO

If yes, please list:

_____

_____

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 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: _____

Over-the-counter medications: _____

Supplements: _____

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

Were there any complications? YES NO

If yes, explain?

_____

_____

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

JAUNDICE RASHES SEIZURES

Birth injuries:_____ Birth Defects:_____ Other:_____

Diet

How was your infant fed?

Breast fed. How long? _____ Formula. Milk/Soy/Other: _____

Other: _____

Where foods introduced 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 (ie. Religious, vegetarian/vegan)? YES NO
If yes, please list:

_____

_____

Describe a typical day's diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (and total quantity) _____

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?

_____

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

_____

Family History

Do you know the family medical history? YES NO

Indicate if a close relative (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 does your child watch?_____ hr per day/week

How often does your child read, or is read to (not for school)? Daily Several times/wk 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?_____

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

_____

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

_____