

DEVELOPMENTAL HISTORY – Please indicate the month/year in which your child first did the following, if applicable:

| | | |
|-----------------------|------------------------|----------------------|
| Smiled _____ | Lifted head _____ | Rolled over _____ |
| Laughed / cooed _____ | Sat up _____ | Crawled _____ |
| Walked _____ | Spoke first word _____ | Toilet trained _____ |
| Dressed self _____ | Rode bicycle _____ | Tied shoelaces _____ |

Additional notes: _____

SOCIAL HISTORY – Please explain any problems or concerns you, or your child have in the following areas:

Appearance / height / weight _____

Behaviour _____

Friends _____

Grades / learning abilities _____

Computer / TV / video games use _____

Sex / sexuality _____

Alcohol / drug use _____

Does your child exercise? If yes, what forms? _____ How often? _____

Is your child exposed to any of the following? pets smoke pesticides or other toxic chemicals

Do you have reason to believe that your child is being or has ever been physically, emotionally, or sexually abused? Y N - if yes, please provide details: _____

DIET – Please outline a typical day of your child's diet

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

When were solid foods first introduced? _____ Any adverse reactions? _____

Any food cravings? _____ Aversions? _____

Dietary restrictions (e.g. religious, vegetarian)? _____

OTHER CONCERNS – Please list any other information relevant to your child's health that has not been addressed.

This is to certify that I have answered the questions on the form to the best of my knowledge. I understand that to provide incorrect information about my child's health and/or symptoms may place my child's health at risk.

Signature of parent/guardian

Date

FAMILY MEDICAL HISTORY – Please ✓ if anyone in the child’s family (mother, father, grandparents, siblings) currently has or has had in the past any of the following:
If you don’t have information about the biological family’s medical history please skip the following section

P=Past C=Current

| | P | C | Relationship | | P | C | Relationship |
|---------------------|--------------------------|--------------------------|---------------------|-----------------|--------------------------|--------------------------|---------------------|
| Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> | _____ | HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Allergies | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Lung disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Asthma/emphysema | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Mental disorder | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Birth defects | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Muscle disorder | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Skin disorder | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Epilepsy/seizures | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Eye/ear disorder | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Thyroid disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Other | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

PRENATAL HISTORY

Duration of pregnancy: _____ Food cravings: _____
 Any nausea/vomiting? _____ High blood pressure? _____
 Diabetes? _____ Other illnesses/infections: _____
 Medications/supplements: _____
 Medical interventions (e.g. amniocentesis): _____
 Complications? _____ Prenatal care: _____
 Mother’s physical and emotional health during pregnancy: _____

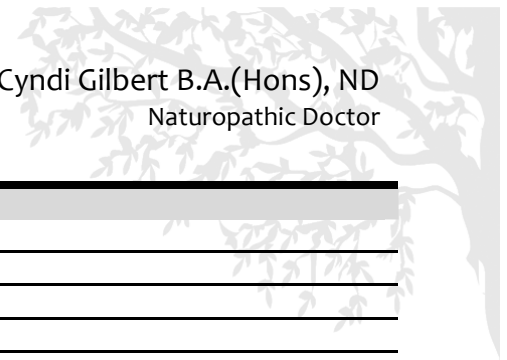
 Father’s health at conception: _____
 Social support during pregnancy: _____
 How much alcohol? _____ Tobacco? _____ Recreational drugs? _____

THE BIRTH EXPERIENCE

Mother’s age at birth: _____ Prior miscarriage(s) Length of labour: _____
 Location of birth: _____ Natal support: _____
 Delivery: Premature On time Late Induced Vaginal Breech C-section
 Medications/supplements used: _____
 Instrumentation used (e.g. forceps, suction): _____
 Complications during delivery? _____

NEONATAL HISTORY

Birth weight: _____ AGPAR score (if known): _____
 Interventions at birth (e.g. vitamin K, antibiotic eye drops): _____
 Complications after birth? _____
 Feeding: Breast fed Formula fed Type/brand of formula: _____
 How long (months/years)? _____ How often per day? _____
 Any difficulties with feeding? _____



| HOSPITALIZATIONS / INJURIES / SERIOUS ILLNESSES | | |
|---|------|---------|
| Reason / Injury / Illness | Date | Outcome |
| | | |
| | | |
| | | |
| | | |

| HISTORY OF VACCINATIONS | | |
|--|---------|-------------------|
| Type | Date(s) | Adverse Reactions |
| DTaP-IPV (Diphtheria, Tetanus, Pertussis, Polio) | | |
| Pneumococcus | | |
| Hib (Hemophilus influenza b) | | |
| MMR (Measles, Mumps, Rubella) | | |
| Influenza | | |
| Varicella (Chicken Pox) | | |
| Meningococcus | | |
| Hepatitis B | | |
| Other: | | |

| CURRENT MEDICATIONS & SUPPLEMENTS | | | |
|-----------------------------------|------|-------------------|--------------|
| List | Dose | Reason for taking | Side Effects |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| PAST MEDICATIONS & SUPPLEMENTS | | | | |
|--------------------------------|------|-------|--------|--------------|
| List | Dose | Dates | Reason | Side Effects |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

of courses of Antibiotics: _____

Pediatric Intake Form

PERSONAL & CONTACT INFORMATION:

Name: _____ Address: _____
 Nickname: _____ Sex: _____
 Age: _____ Date of Birth: _____ Height: _____ Weight: _____
 Parent/Guardian: _____ Parent/Guardian: _____
 Phone 1: _____ Phone 2: _____ Phone 1: _____ Phone 2: _____
 E-mail: _____ E-mail: _____

Emergency contact: _____ Relationship: _____
 Phone 1: _____ Phone 2: _____

OTHER HEALTH CARE PROVIDERS – Please put a “*” beside the name of the child’s primary practitioner

Name: _____ Practice Type: _____ Phone: _____
 Name: _____ Practice Type: _____ Phone: _____
 Name: _____ Practice Type: _____ Phone: _____

HOW DID YOU HEAR ABOUT CYNDI GILBERT, ND?

WHAT ARE YOUR TOP CONCERNS ABOUT YOUR CHILD’S HEALTH?

1) _____
 2) _____ 4) _____
 3) _____ 5) _____

MEDICAL HISTORY – Please ✓ if your child currently has or has had in the past any of the following conditions:

P=Past C=Current

| | P | C | Details | | P | C | Details |
|--------------------------|--------------------------|--------------------------|----------------|-----------------------|--------------------------|--------------------------|----------------|
| Anemia/sickle cell | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Immune deficiency/HIV | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Allergies | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Appetite (poor/excess) | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Learning disorders | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Measles | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Bed wetting (persistent) | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Mumps | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Birth defect | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Nose bleeds | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Blood transfusion | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Broken bones/sprains | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Posture problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Chicken pox | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Congenital anomaly | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Rubella | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Croup | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Sinus infections | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Skin rashes/itching | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diaper rash | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Sleep disturbances | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diarrhea/constipation | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Speech problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Epilepsy/seizures | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Stomach aches | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Ear infections | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Strep throat | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Eye infections | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Thumb sucking | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Frequent colds/flu | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Whooping cough | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Headaches | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Other: | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Hyperactivity | <input type="checkbox"/> | <input type="checkbox"/> | _____ | Other: | <input type="checkbox"/> | <input type="checkbox"/> | _____ |