

**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?**

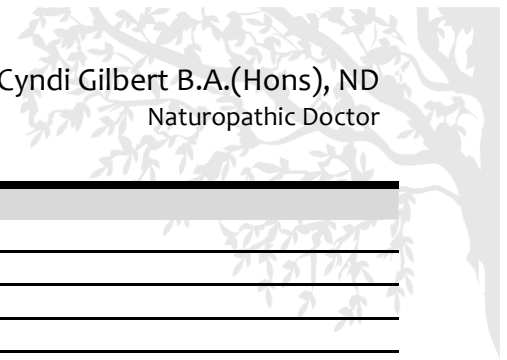
**WHAT ARE YOUR TOP CONCERNS ABOUT YOUR CHILD’S HEALTH?**

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**

	<b>P</b>	<b>C</b>	<b>Details</b>		<b>P</b>	<b>C</b>	<b>Details</b>
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"/>	_____



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: \_\_\_\_\_

**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**

	<b>P</b>	<b>C</b>	<b>Relationship</b>		<b>P</b>	<b>C</b>	<b>Relationship</b>
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**

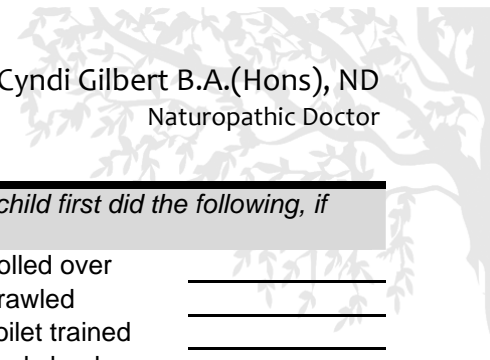
Duration of pregnancy: \_\_\_\_\_ Food cravings: \_\_\_\_\_  
 Any nausea/vomiting? \_\_\_\_\_ High blood pressure? \_\_\_\_\_  
 Diabetes? \_\_\_\_\_ Other illnesses/infections: \_\_\_\_\_  
 Medications/supplements: \_\_\_\_\_  
 Medical interventions (e.g. amniocentesis): \_\_\_\_\_  
 Complications? \_\_\_\_\_ 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? \_\_\_\_\_



**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