Children's Intake Form

Name: _____ Date of Birth: _____
Age: _____ M/F_____

Parent / Guardian _____
Contact Phone Number_____
Email: _____
Would you like to be included in our sporadic wellness e-newsletters? _____
Addresss: _____
_____
_____

What are your child's main health concerns?

_____
_____
_____

Has your child been vaccinated? Did you notice any changes or ill effects after vaccination?

_____
_____
_____

Please Mark which vaccinations your child has had:

DTaP-IPV-Hib (Diphtheria, Tetanus, Whooping Cough, Polio, Hib)			
Pneu-C-7 (Pneumococcal disease)		**Men-C**: Meningococcal disease	
Influenza		**MMR**: Measles, Mumps, Rubella	
Varicella: Chicken Pox		**HPV Vaccine**	

Please Circle which of these conditions your child has had:

Jaundice		Low Energy		Hyperactivity		Bedwetting		Convulsions	
Ear Infections		Skin Conditions		Constipations		Vision Problems		Speech Problems	
Colic		Sleep problems		Learning Difficulties		Breathing problems		Heart Murmur	
Diarrhea		Teeth Problems		Allergies		Behavioural problems			

Any Surgeries:	When?	Complications?

Birth History:

Weight at Birth: _____
Any complications during labour, delivery or after delivery?
_____
_____
_____

Forceps/ Vaccum		Premature		Ceseasean	
Epidural		Pitocin / Oxytocin		Induction	
Other Medications					

Did the child breastfeed? _____ If yes until what age? _____
When were solids first introduced? _____
What were the first foods introduced? _____

Are there any milestones your child was slow to reach or had difficulty with?
_____
_____
_____

History of Mother's Pregnancy:

Any emotional stresses in pregnancy?
_____
_____
_____

Any physical stresses (illness) in pregnancy?
_____
_____
_____

Were any medications, cigarettes, coffee, antibiotics, etc used during the pregnancy, if so which ones?
_____
_____
_____

Are there any major ailments that are prevalent in the immediate or extended family?
_____
_____
_____

Primary Physician:
Name: _____ Phone #: _____