

Pediatric Intake Form

Please fill out this form and email it to drhanlon@ndoc.ca.

Note: If fonts are not loading in Acrobat, please open this form in your web browser.

Today's Date:

Name:

Birth Date: Gender:

Guardian Name: Relationship:

Address: City: Province:

Postal Code: Email:

Home Phone: () Work Phone: () Cell: ()

Preferred Method of Contact: Home Work Cell Email

Whom does the child live with?

What are the child's health concerns, in order of importance?

1.
2.
3.
4.
5.

Medical History

How would you describe your child's general state of health? (please check)

Excellent Good Fair Poor

How would you describe your child's energy level? /10 (0 = no energy, 10 = an abundance of energy).

Please indicate any serious condition, illnesses or injuries, and any hospitalizations/surgeries along with approximate dates:

Which of the following has your child had?

- | | | | |
|--------------------------------------|--|---|---|
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Mumps | <input type="checkbox"/> Whooping cough | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Roseola | <input type="checkbox"/> Strep throat | <input type="checkbox"/> Ear infections |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Impetigo | <input type="checkbox"/> Herpes Simplex |

Has there been a significant gain or loss of weight? Y N

Has there been a failure to gain weight appropriate to the child's age? Y N

Does your child have any allergies (medicines, environmental, etc.). If yes, please record reaction to allergen (rash, itching, runny nose, watery eyes, difficulty breathing, etc.)?

Does your child have any food allergies and/or intolerance? Please list food item and reaction to allergen.

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.). Please list dose, frequency, and brand name.

Please list past prescription medications.

How many times has your child been treated with antibiotics?

Please indicate the immunizations your child has had; please indicate date(s) of immunizations:

- | | | | |
|---|----------------------|--------------------------------------|----------------------|
| <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus) | <input type="text"/> | <input type="checkbox"/> Flu | <input type="text"/> |
| <input type="checkbox"/> Tetanus booster | <input type="text"/> | <input type="checkbox"/> Polio | <input type="text"/> |
| <input type="checkbox"/> MMR (mumps, measles, rubella) | <input type="text"/> | <input type="checkbox"/> Hepatitis B | <input type="text"/> |
| <input type="checkbox"/> Haemophilus influenza B | <input type="text"/> | <input type="checkbox"/> Hepatitis A | <input type="text"/> |
| <input type="checkbox"/> Other? | <input type="text"/> | | |

Please indicate if any caused adverse reactions (for example, fever, rash, ear ache, behavioural disturbances, etc.) immediately or up to a month following vaccinations:

Family History

Please indicate if a close relative (grandparent, parent, sibling) has or has had any of the following and provide the relationship to the child :

<input type="checkbox"/> Alcoholism	<input type="text"/>	<input type="checkbox"/> Hodgkin's	<input type="text"/>
<input type="checkbox"/> Allergies	<input type="text"/>	<input type="checkbox"/> Hypertension	<input type="text"/>
<input type="checkbox"/> Arthritis	<input type="text"/>	<input type="checkbox"/> Juvenile arthritis	<input type="text"/>
<input type="checkbox"/> Asthma	<input type="text"/>	<input type="checkbox"/> Kidney disease	<input type="text"/>
<input type="checkbox"/> Autoimmune disease	<input type="text"/>	<input type="checkbox"/> Learning disability	<input type="text"/>
<input type="checkbox"/> Blood disorder	<input type="text"/>	<input type="checkbox"/> Mental illness	<input type="text"/>
<input type="checkbox"/> Birth defects	<input type="text"/>	<input type="checkbox"/> Seizure disorder	<input type="text"/>
<input type="checkbox"/> Cancer	<input type="text"/>	<input type="checkbox"/> Sickle cell anemia	<input type="text"/>
<input type="checkbox"/> Cardiovascular disease	<input type="text"/>	<input type="checkbox"/> Stroke	<input type="text"/>
<input type="checkbox"/> Diabetes (I or II)	<input type="text"/>	<input type="checkbox"/> Tuberculosis	<input type="text"/>
<input type="checkbox"/> Endocrine disease	<input type="text"/>	<input type="checkbox"/> Other	<input type="text"/>

Do either of the parents/guardians and/or siblings have a chronic illness?

Grandparents' History:

	Age		
	Alive/Deceased	(at death)	Major Health Conditions
Maternal grandmother	<input type="text"/>	<input type="text"/>	<input type="text"/>
Maternal grandfather	<input type="text"/>	<input type="text"/>	<input type="text"/>
Paternal grandmother	<input type="text"/>	<input type="text"/>	<input type="text"/>
Paternal grandfather	<input type="text"/>	<input type="text"/>	<input type="text"/>