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## Child Intake

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex M F

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

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

**Child's Medical History**

Please indicate any serious conditions, illness or injuries, and any hospitalizations, along with approximate dates:

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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.)?

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Please list all CURRENT medication (Prescription, over-the-counter, vitamins, herbs, homeopathics, etc.).

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Please list all PAST prescription medications.

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How many times has your child been treated with ANTIBIOTICS? \_\_\_\_\_

Which of the following immunizations has your child had?

- DPP(diphtheria, pertussis, tetanus)     Haemophius influenza     Hepatitis B
- Tetanus booster: when? \_\_\_\_\_     "Flu"     Hepatitis A
- MMR(measles, mumps, rubella)     Polio     Chicken Pox
- Other \_\_\_\_\_

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

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Has your child had any screening test (i.e. blood, hearing, vision)?     Yes     No

If yes please list:

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**Child's 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:

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What foods were introduced between 6-12 months?

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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:

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Does your child have any dietary restrictions (i.e. religious, vegetarian/vegan)?  Yes  No

If yes please list:

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Describe a typical day's diet for your child

Breakfast _____	Snacks _____
Lunch _____	Beverages: _____
Dinner _____	Type? _____
	How many? _____

**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:

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Describe your child's temperament:

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Describe your child's behaviour and performance at school:

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## 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 the time of this 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: List? \_\_\_\_\_  
Over-the-counter Medications: List? \_\_\_\_\_  
Supplements: List? \_\_\_\_\_  
Tobacco Alcohol 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 the birth?

- Jaundice Rashes Seizures  
Birth injuries: \_\_\_\_\_ Birth defects: \_\_\_\_\_  
Other: \_\_\_\_\_

## Family History

Do you know the family medical history? Yes No

Indicate if a close relatives (i.e. 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.

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## Child's Environment

Is the child in? School Daycare Home care Other

What are the child's favourite activities?

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Does the child exercise regularly? Yes No

How much? \_\_\_\_\_

How often? \_\_\_\_\_

How much television does your child watch? \_\_\_\_\_ hrs. per day/week

How often does your child read, or is read to (not for school)?

Daily Several times a week 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? \_\_\_\_\_

How is the child's home heated? \_\_\_\_\_

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

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

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