6243 Almon St, Halifax, Nova Scotia B3L 1V1 – P:902.407.0808 – F:902.407.0809

Pediatric Intake

Date: _____ Initial Visit Date:_____

Thank you for taking the time to fill out this form. The information is very important in the assessment of your child.

Patients Name: Age: Sex: D.O.B.:

Parent A Name:	Phone Number (h)	(w)
Parent B Name:	Phone Number (h)	(w)
Home Address:		
How did vou hear about this Clinic?		

Name of Physician, Clinic or Hospital where your child's records are kept:
Name:_____ Phone:_____
Address: _____
_____
Reason for referral or presenting problems:_____
_____
_____

MEDICATIONS

	Past	Present		Past	Present
Aspirin			Antibiotics		
Tylenol			Anti-histamine		
Decongestant			Other		
Ventolin/ Pulmocort			Allergies to medicines		

Supplements:_____

MEDICAL HISTORY

Childhood Illness (Please check those which your child has experienced)

	Chicken Pox		Scarlet Fever		Tonsillitis, approx. #: ___
	Measles		Pneumonia		Ear Infections #: ___
	Mumps		Frequent Colds		Other: (please list)
	Rubella		Rheumatic Fever		

Has your child had any other following tests?

	When	Where	Results	
Psychological Evaluation				
Electroencephalogram				
Hearing				
Speech/language				

Injuries/Surgeries/Hospitalizations (Please list):_____
_____
_____

IMMUNIZATIONS

	Measles		Mumps		DPT
	Diptheria		Smallpox		Other (list)
	Influenza		Tetanus		
	Polio		MMR		

Reactions to vaccination?_____

FAMILY HISTORY

	Heart Disease		Diabetes		Birth Defects
	Hypertension		Arthritis		Tuberculosis
	Cancer		Allergies		Mental Illness

Previous Pregnancies by birth mother, miscarriages or complications:_____

_____

_____

Mother's age at child's birth? _____

Mother's health during pregnancy?

	Bleeding		Nausea		Cigarettes/
	Illness		Hypertension		Alcohol/
	Thyroid Problems		Medications		Drug Consumption
	Diabetes		Physical or Emotional Trauma		

BIRTH HISTORY

Term: _____ Full_____ Premature_____ Later Weight at Birth_____

Length of Labour:_____ Complications?_____

Has your baby had any of the following problems?

	Jaundice		Diarrhea		Birth Defects
	Rashes		Colic		Fever
	Cerebral Palsy		Allergies		Blue Baby
	Seizures		Birth injuries (other)- Explain		

Child's sleeping patterns (first year):_____

Food intolerances (if any): _____

Feeding: Breast Fed? _____How long? _____Formula? _____Milk/Soy?_____

Age began solid food? _____

Age began: Sitting: _____ Crawling:_____ Walking:____ First Words:_____

SYMPTOMS: (mark **Y** – if current, **P** for past symptoms)

	Hives		Burning of Urine		Bloody Urine
	Eczema		Frequent Urination		Cries Easily
	Bleeding Gums		Heart Murmur		Sleep Problems
	Nose Bleeds		Vomiting Spells		Nervous
	Acne		Anemia		Night Sweats
	High Fever		Stomach Aches		Sensitive to Light
	Chronic Rash		Jaundice		Body/Breath Odor
	Hearing Loss		Easy Bruising		Motion/Car Sickness
	Diarrhea		Flat Feet		No Appetite
	Sore Throats		Constipation		Nightmares
	Frequent Headaches		Gas		Canker Sores
	Frequent Colds		Bleeding Tendency		Unusual Fears
	Wheezing		Joint Pains		Excessive Fatigue
	Cough		Dizzy Spells		Hair Loss

DIET

Please describe your child's typical diet: _____

_____

_____

_____

_____