



## PEDIATRIC INTAKE FORM

### PATIENT INFORMATION

First & Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M or F

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Names of Parents/ Guardians: \_\_\_\_\_

Address: \_\_\_\_\_

Town/City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Work Phone number: \_\_\_\_\_

Email: \_\_\_\_\_

#### *Emergency Contact:*

\_\_\_\_\_

Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Patient's Primary Care Physician/Pediatrician:

\_\_\_\_\_

Phone Number: \_\_\_\_\_ Address: \_\_\_\_\_

Person Completing this form: \_\_\_\_\_

Relationship: \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

Were you referred to our office? Y or N If yes, by whom?

\_\_\_\_\_

## MEDICAL HISTORY

Purpose of the visit to our office?

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How long has you child been experiencing this?

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Other health care providers consulted:

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Treatments previously tried:

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Please list any other Health Concerns with your child:

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Please indicate if your child has experienced any of the following conditions currently {c} or in the past {p}.

|                     |        |                          |        |
|---------------------|--------|--------------------------|--------|
| Measles             | C or P | Seizures                 | C or P |
| Chicken pox         | C or P | Scarlet fever            | C or P |
| Mononucleosis       | C or P | Colic/gas/cramping       | C or P |
| Mumps               | C or P | Diarrhea                 | C or P |
| Ear infections      | C or P | Digestive difficulties   | C or P |
| Pneumonia           | C or P | Constipation             | C or P |
| Headaches           | C or P | Frequent colds           | C or P |
| ADD/ADHD            | C or P | Coughing/wheezing        | C or P |
| Rubella             | C or P | Sinus problems           | C or P |
| Asthma              | C or P | Cold sores               | C or P |
| Hives/rashes/eczema | C or P | Strep throat/tonsillitis | C or P |
| Allergies           | C or P | Chronic runny nose       | C or P |



Please list any allergies (environmental, food, medications):

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Please list any past surgeries or hospitalizations, including dates and reason why:

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### **FAMILY HISTORY**

Please indicate whether any family member has/had any of the following:

|                    | Family member |                       | Family member |
|--------------------|---------------|-----------------------|---------------|
| Cancer             |               | Autoimmune disease    |               |
| Heart disease      |               | Allergies             |               |
| Diabetes           |               | Alcoholism            |               |
| Tuberculosis       |               | Congenital conditions |               |
| Depression/anxiety |               | Genetic abnormalities |               |
| Mental Illness     |               | Bleeding disorders    |               |

### **PRENATAL HISTORY**

Name of the midwife/Obstetrician/health care provider:

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What was the health of the parents at the time of the conception?

Mother    poor    fair    good    excellent    unknown  
Father    poor    fair    good    excellent    unknown