KLEINBURG
INTEGRATIVE HEALTH

TEL. 905.893.2898
FAX. 1.833.523.2466
RECEPTION@KIHCLINIC.COM

PEDIATRIC INTAKE FORM (BIRTH TO 9 YEARS)

Please Complete and Return to Reception

Patient's Name: _____ Date _____

Age:_____ Date of Birth:_____ Gender: Female / Male

Parent/Guardian's Name: _____

Address:_____

City/Postal Code:_____

Telephone number: Home:_____ Work:_____

Parents e-mail address:_____

May we leave messages relating to your child's visits? Y / N

How did you hear about this Clinic?:_____

If internet: Google:___ OAND website:____ CAND Website:____ Other: _____

Has any other family member already been a patient at this clinic?_____

Name of doctor's office/hospital/clinic where your child's health records are kept

_____

Reason(s) for visit today?_____

_____

MEDICATIONS

NOW	PAST		NOW	PAST	
_____	_____	Aspirin	_____	_____	Decongestants
_____	_____	Tylenol	_____	_____	Anti-histamine

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_____ _____ Antibiotics _____ _____ Other

_____

_____ _____ Ibuprofen Allergies to

medicines:_____

MEDICAL HISTORY

_____ Chicken pox _____ Scarlet fever _____ Tonsillitis, no. times: _____

_____ Measles _____ Pneumonia _____ Ear infxns, no. times: _____ _____ Mumps _____ Frequent cold

_____ Strep throat, no. times: _____

_____ Rubella _____ Rheumatic fever Other

_____

Has your child ever had any of the following? WHEN WHERE RESULTS

Electroencephalogram (EEG):_____

Psychological evaluations:_____

WHEN WHERE RESULTS

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Hearing test:_____

Speech/language tests_____

Injuires/surgeries/hospitalizations (please list):_____

IMMUNIZATIONS

_____ MMR _____ DPT _____ Chicken pox Others:

_____

_____ Measles _____ Diphtheria _____ Small pox Adverse

Reactions: Y / N _____ Tetanus _____ Strep

_____ H. influenza If so, what? _____

_____ Rubella _____ Polio _____ The flu

_____

FAMILY MEDICAL HISTORY (Please circle and list who):

Heart disease	Diabetes	Birth defects
Hypertension	Arthritis	Tuberculosis
Cancer	Allergies	Asthma
Mental illness	Ospeoporosis	Other significant

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications?_____

_____

Mother's age at child's birth:_____

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Mother's health during pregnancy (please circle):

Bleeding Nausea Physical or emotional trauma

Illnesses Hypertension Cigarettes, alcohol, drug consumption

Medications (which)_____ Diabetes Thyroid problems

BIRTH HISTORY

Term: _____ Full _____ Premature _____Late Weight at birth:_____

Length of labor:_____ Complications:_____

Did your child have any of the following problems shortly after birth (please circle)?

Rashes Birth injuries Blue baby

Jaundice Seizures Cerebral palsy

Colic Fever Birth defects

Other:_____

Child's sleep patterns (1st year):_____

Food intolerances: _____

Breast fed: Y / N How long: _____ Formula: Y / N Type (milk, soy): _____

Age began solids: _____ Which foods were first introduced? _____

_____

Age began: Sitting_____ Crawling_____ Walking_____ Talking_____

SYMPTOMS

_____ Hives _____ Burning urine _____ Bloody urine _____ Eczema

_____ Cries easily _____ Bleeding gums _____ Heart murmur _____ Nervous

_____ Nose Bleeds _____ Vomiting spells _____ Sleep problems _____ Asthma

_____ Acne _____ Anemia _____ Night sweats _____ High fever

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_____ Jaundice _____ Sensitive to light _____ Chronic rash _____ Stomach aches

_____ Diarrhea _____ Hearing loss _____ Easy bruising _____ Sore throats

_____ Flat feet _____ No appetite _____ Body/breath odor _____ Constipation

_____ Nightmares _____ Frequent colds _____ Bleeding tendency _____ Unusual fears

_____ Wheezing _____ Joint pains _____ Excessive fatigue _____ Cough

_____ Dizzy spells _____ Hair loss _____ Frequent urination _____ Allergies

DIET

Please describe your child's typical daily diet:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

To drink:_____

THANK YOU. I LOOK FORWARD TO HELPING YOU CHILD IN ANY WAY I CAN.