KLEINBURG
INTEGRATIVE HEALTH

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
_____	_____	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**

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:_____

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
_____ 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.