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Child Intake Form (age 0-11) Date _____

Child's name _____**Date of birth** _____ **Sex M F**

Age _____ Referred by _____

Who is filling out this form (name and relation)? _____

Current Height of child _____ Current Weight of child _____

Contacts (in order of preference)

Name _____ Tel: Home_____

Address _____ Work_____

_____ Other_____

Relationship to child _____

Name _____ Tel: Home_____

Address _____ Work_____

_____ Other_____

Relationship to child _____

Whom does the child live with?_____

Other health care providers (pediatrician, family physician, etc)

1.	2.	3.
_____	_____	_____
_____	_____	_____
_____	_____	_____
(_____)_____	(_____)_____	(_____)_____

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

Primary Health Concern _____

At what age did this condition begin? _____

What (if anything) has been used to treat this condition and was it effective? _____

Other Health Concerns:

1._____

2._____

3._____

4._____

Medical History

How would you describe your child's general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates: _____

Date of child's last medical exam _____

Which of the following has your child had? (Please Check)

	Rubella (German measles)		Rheumatic fever		Impetigo
	Measles		Scarlet fever		Roseola
	Chicken pox		Whooping cough		Mumps

Has your child had any of the following conditions? (Please Check)

	Strep throat		Asthma		Diarrhea
	Frequent colds		Skin rashes		Constipation
	Recurring fevers		Seizures		Bedwetting Problems
	Ear Infections		Allergies		Temper Tantrums
	Colic		Headaches		Heat/Cold Intolerance

Does your child have any allergies (medicines, environmental, etc.)?_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

_____

_____

Please list any past prescription medications.

_____

How many times has your child been treated with antibiotics? _____

Please indicate what immunizations your child has had

☐ DPT (diphtheria, pertussis, tetanus)	☐ Haemophilus influenza B	☐ Hepatitis B
☐ Tetanus booster; when? _____	☐ "Flu"	☐ Hepatitis A
☐ MMR (measles, mumps, rubella)	☐ Chicken Pox	☐ Polio

Other _____

Please indicate if any of the above vaccines caused adverse reactions

_____

What screening tests has your child had (blood, hearing, vision, etc.) _____

Has your child ever faced any significant physical or emotional traumas? Please List

_____

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 (physically and emotionally) of the mother during the pregnancy?

Poor Fair Good Excellent Unknown

How was the mother's diet during pregnancy?

Poor Fair Good Excellent Unknown

Did the mother experience any of the following during the pregnancy:

☐ Bleeding	☐ High blood pressure	☐ Nausea	☐ Vomiting
☐ Diabetes	☐ Thyroid problems	☐ Physical or emotional trauma	

Other _____

Did the mother receive prenatal medical care? Y N Unknown

What was the mother's age at child's birth? _____

Did the mother use any of the following during the pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational drugs:_____

☐ Prescription medications:_____

☐ Over-the-counter medications:_____

☐ Supplements:_____

☐ Other:_____

Birth history

Term length: ☐ Full ☐ Premature: _____ wks ☐ Late: _____ wks

Length of labour: _____ Weight at birth _____

Any complications?_____

Was the birth (Circle): Vaginal C-section Induced Forceps Anesthesia/Epidural used

Did the child experience any of the following at or shortly after birth?

☐ Jaundice ☐ Rashes ☐ Seizures ☐ Birth injuries/Birth Defects_____

☐ Difficulty Feeding ☐ Other_____

Diet

How was your infant fed?

☐ Breast fed. How long? _____ ☐ Formula. Milk/Soy/Other: _____

☐ Other: _____

What foods were introduced before 6 months? (Please list approximate month as well.)

_____

_____

Would you consider your child a picky/fussy eater? Yes No

Does your child have any food allergies or intolerances? Please list.

_____

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____

Describe a typical day's diet

Breakfast _____

Lunch_____

Dinner_____

Snacks_____

Beverages (and total quantity)_____

Health and Development

How was your child's health in the first year? Poor Fair Good Excellent Unknown

At what age did your child start to….?

Sit up _____ Crawl _____ Walk _____ Talk _____

Does your child use any special aids or devices on a daily basis (i.e. glasses, hearing aid, walking aids, artificial limbs, communication device, other)?_____

Has your child ever received any of the following?
□ Occupational therapy □ Physical therapy □ Speech therapy □ Tutor □ ABA

Family history

Indicate if a close relative (parent, sibling, grandparent) has had any of the following:

	Who?		Who?
Allergies		Diabetes	
Asthma		Kidney disease	
Birth defects		Skin problems	
Juvenile arthritis		Migraines/Headaches	
Bleeding Disorder		Depression/Mental Illness	
Seizures		Inherited/Genetic Disease	
Heart Disease		Other	

☐ I don't know the family medical history

Do either of the parents have a chronic illness? Yes No Please describe

_____

Sleep

Does your child have any problems associated with sleeping (i.e. problems falling asleep, trouble waking, etc.)?_____

What time does your child usually go to bed? _____

Does your child have nightmares? □ Yes □ No how often? _____

Does your child nap during the day? □ Yes □ No what time(s)? _____

Social Patterns

Is the child in: School Daycare Home care Other_____

How would you describe your child's personality?

_____

What motivates your child? What are your child's favorite activities and interests?_____

Do you have any concerns with your child's performance at school? Yes No

Does your child have any behaviors you are concerned with? Yes No

How many hours a day does your child…?

Watch TV _____ Use Computer _____ Play Video Games _____

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

☐ Daily ☐ Several times a week ☐ Weekly ☐ Less than weekly

Is your child involved in any recreational activities or regular exercise? Please List_____

What are some things that are currently stressful to your child?_____

Has your family experienced any of the following challenges?

□ Divorce □ Death of a family member
□ Exposure to violence □ Substance abuse
□ Disabling injury □ None

Environment

Does anyone in the child's household smoke? Y N

Are there animals in the home? Y N

Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)? Please describe._____

Is there anything about your child or the family that you feel is important that has not been covered?

_____

_____

_____

Thank you for taking the time to fill in this comprehensive questionnaire. It will be a valuable resource in understanding your child's health.