



**Pediatric Intake (Child up to the age of 12)**

**PATIENT INFORMATION**

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: Male Female  
Day/Month/Year

Ethnicity: \_\_\_\_\_

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

**PARENT / GUARDIAN'S CONTACT INFORMATION:**

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

Telephone: (home) \_\_\_\_\_ (work) \_\_\_\_\_  
(mobile) \_\_\_\_\_ Email: \_\_\_\_\_

How can we best reach you?

Marital Status: \_\_\_Single \_\_\_Married \_\_\_Divorced \_\_\_Separated \_\_\_Living with Partner \_\_\_Widowed

Other parent/guardian authorized to make decisions regarding this minor child?

If custody is shared, please indicate the child's living arrangements:

\_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

(\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Telephone (home) Work Mobile / Pager

Does this child have any siblings? Y N

If yes, list age and gender: \_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_ Tel: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

Date of last visit to Medical Doctor: \_\_\_\_\_ Date last physical: \_\_\_\_\_

Is this child under the care of any other health care providers?

(name) \_\_\_\_\_ (specialty) \_\_\_\_\_

(contact)  
How did you hear of this clinic/were referred by who? \_\_\_\_\_

## CONTEXT OF CARE

1. Why did you choose to bring your child to this clinic, and what do you know about our approach?

2. What three expectations do you have from your child's visit to our clinic?

3. What long term expectations do you have from working with us?

4. What is your present level of commitment to addressing any underlying causes of your child's signs and symptoms that relate to diet and lifestyle? (Rate from 1 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

5. a) Please list the behaviors or lifestyle habits that your child or family currently engage in *regularly*, that you believe support your child's health:

b) Please list the behaviors or lifestyle habits that your child or family currently engage in *regularly* that you believe are self destructive:

6. What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your child's health and in adhering to the therapeutic protocols which we will be sharing with you?

7. Will the other members of your family *sincerely and consistently* support and participate in the lifestyle changes you will be making for your child?

8. What does your child LOVE to do?

**MEDICAL HISTORY**

Please list your child's **health concerns**. (Both yours and their own, if any.)

Concern	Since	Concern	Since
1.		4.	
2.		5.	
3.		6.	

Have any of these issues changed or worsened over time?

What effect have these issues had on your child's life?

How would you describe your child's general state of health?

Please list any **major trauma, injury, or accident** (mental, emotional or physical) your child has sustained.

Incident	Date	Long-term effects

Please list any **surgical procedures** your child has undergone.

Procedure	Date	Complications / Results

Please list any other forms of treatment that your child has received and describe their effectiveness.

**CHILDHOOD ILLNESSES** (circle all that apply & indicate the date):

- |                |               |               |                          |          |
|----------------|---------------|---------------|--------------------------|----------|
| Chicken pox    | Measles       | Mumps         | Rheumatic Fever          | Roseola  |
| Polio          | Scarlet fever | Tuberculosis  | Whooping Cough           | Impetigo |
| Ear Infections | Strep Throat  | Mononucleosis | Rubella (German measles) |          |

**MEDICATIONS / SUPPLEMENTS / OTHER SUBSTANCES**

Please list all current medications and supplements your child takes including prescription drugs, over the counter drugs, herbs, vitamins, minerals, homeopathics, etc.

DRUG/SUPPLEMENT	USED FOR	DATE STARTED	DOSAGE/ FREQUENCY

How often has your child taken antibiotics? \_\_\_\_\_  
 Date of most recent course of antibiotics? \_\_\_\_\_

**CHILDHOOD VACCINATIONS:**

Please indicate which of the following vaccinations your child has received, and any side effects.

Vaccination	Y or N	Date	Side Effects?
DPT (diphtheria, pertussis, tetanus)			
Tetanus Booster			
MMR (measles, mumps, rubella)			
Haemophilus influenza B			
“Flu shot”			
Polio			
Hepatitis A			
Hepatitis B			
Varicella (chicken pox)			
Other			

**ALLERGIES, SENSITIVITIES, EXPOSURES:**

Please list any known or suspected allergies, sensitivities and/or intolerances.

Drugs	Food	Environmental/Chemical

Has your child ever been exposed to toxic substances such as pesticides, herbicides, solvents, or sprays? If yes, please give details:

Has your child ever been exposed to heavy metals such as lead, mercury, arsenic, cadmium, or second hand smoke? If yes, please give details:

Does your child have any sudden onset of symptoms (headaches, rashes, nausea, fatigue, shortness of breath, etc) when exposed to chemicals, mold, dust, pollen, or other environmental allergens? If so, please explain.

Has your child undergone any type of allergy testing? What kind? When? Results?



**INFANCY:**

Birth weight: \_\_\_\_\_ Birth length: \_\_\_\_\_

Any health concerns at birth?

In the first few weeks did your child experience any of the following (circle any that apply)?

Congenital birth defect      fever      feeding difficulties      infection

Skin conditions      jaundice      restlessness      colic      constipation

Vomiting      Other? \_\_\_\_\_

Age at first:    sitting \_\_\_\_\_    crawling \_\_\_\_\_    teething \_\_\_\_\_    walking \_\_\_\_\_    talking \_\_\_\_\_

Any developmental delays or concerns?

**DIETARY & LIFESTYLE FACTORS:**

Was your child breastfed?      Y    N      If so, for how long?

At what age did you introduce solid foods?  
What order, if any, did you follow in introducing foods?

Did your child display any allergic-type, digestive, or skin reactions to any foods?

Height: \_\_\_\_\_      Current Weight: \_\_\_\_\_  
Concerns about height or weight?

**Please be sure to fill out a diet diary for your child and submit it with these forms.**

Are there any foods you (or your child) exclude from your child's diet? For what reason?

Are there any foods that your child craves specifically? (chocolate, sweets, salty, sour, rich/fatty, breads, spicy)  
At what times?

How is your child's appetite?  
How is your child's thirst?  
How much water does your child drink daily?  
What is the source of this water? (tap, bottled, filtered, well, etc)

What other beverages does your child drink, and how much?

How often does your child have a bowel movement?

What is the quality of your child's bowel movements? (hard/soft, colour, texture, etc)

How would you rate your child's energy level?  
Their stress level?

How many hours of sleep does your child get per night? \_\_\_\_\_ hrs  
What times does your child go to bed and awaken?  
Any problems with sleep?

Does your child take naps?                    Y    N                    For how long / when?

Does your child exercise regularly?   Y    N  
What forms of exercise?  
What duration/frequency/intensity?

How much time does your child spend watching television / using a computer per day?  
How much time does your child spend outdoors per day?

Is your child exposed to:   \_\_\_pets            \_\_\_smoke            \_\_\_chemicals / fumes in the home or at school?

**PSYCHO-SOCIAL:**

What are your child's interests / hobbies?

How does your child feel about school?

Describe your child's disposition:

Does your child / family take part in any spiritual or religious activities? Please describe:

How would you describe the emotional climate of your home?

How does your child get along with other children or siblings?

**ADDITIONAL**

Is there any other information relevant to your child's health that has not been addressed?