

PEDIATRIC INTAKE FORM

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Date of First Visit _____

Patient's Name _____ Gender _____ Birth Date _____ Age _____

Mother's Name _____ Father's Name _____

Home Address _____

Home Phone _____ Emergency # _____ Email Address _____

How did you hear about this office? _____

Name and Address of doctor's office/hospital where your child's records are kept _____

Main reason for presenting to this office _____

Other reasons _____

Medical History

____ Frequent Colds

____ Chicken Pox

____ Pneumonia

____ Allergies

____ Measles

____ Scarlet Fever

____ Tonsillitis-approx # _____

____ Mumps

____ Rheumatic Fever

____ Ear Infection-approx # _____

____ Rubella

____ Other _____

Has your child had any of the following tests? (when? where? results?)

Electroencephalogram _____

Psychological Evaluation _____

Hearing _____

Speech/Language _____

Injuries/ Surgeries/ Hospitalization/ Accidents _____

Medications (Mark **C** if current and **P** for past symptoms)

____ Antibiotics

____ Aspirin

____ Allergies to Medication

____ Decongestant

____ Tylenol

____ Others _____

____ Anti-histamine

____ Ibuprofen

____ Supplements _____

Immunization

____ Measles Mumps Rubella

____ Chicken pox

____ Tetanus

____ Diphtheria Pertussis Tetanus

____ Polio

____ Hepatitis

____ Influenza

____ Others

Family History

____ Heart Disease

____ Diabetes

____ Birth Defect

____ Mental Illness

____ Genetic Defects

____ Hypertension

____ Arthritis

____ Tuberculosis

____ Kidney Disease

____ Other

____ Cancer

____ Allergies

____ Goiter

____ Stomach Disease

Review of Symptoms (Mark **C** if current and **P** for past symptoms)

<input type="checkbox"/> Hives	<input type="checkbox"/> Dizzy Spells	<input type="checkbox"/> Frequent Vomiting	<input type="checkbox"/> Night Sweat
<input type="checkbox"/> Eczema	<input type="checkbox"/> Anemia	<input type="checkbox"/> Changes in Appetite	<input type="checkbox"/> Sensitivity to Light
<input type="checkbox"/> Acne	<input type="checkbox"/> Cough	<input type="checkbox"/> Bleeding Gum	<input type="checkbox"/> Body/ Breath Odor
<input type="checkbox"/> Chronic Rash	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Motion/ Car Sickness
<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Frequent Headaches
<input type="checkbox"/> Excessive Fatigue	<input type="checkbox"/> Burning Urination	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Joint Pain
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Bloody Urine	<input type="checkbox"/> Cries Easily	<input type="checkbox"/> Flat Feet
<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Stomach Aches	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Canker Sores	<input type="checkbox"/> Constipation	<input type="checkbox"/> Unusual Fears	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> High Fever	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Sleep Problem	
<input type="checkbox"/> Nose Bleed	<input type="checkbox"/> Gas	<input type="checkbox"/> Nightmares	

Parent Information

Mother's age at child's birth _____

Father's age at child's birth _____

Father's general health status _____

Mother's health during pregnancy

<input type="checkbox"/> Bleeding	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Physical/ Emotional Trauma
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Cigarette/ Alcohol/ Drug
<input type="checkbox"/> Nausea	<input type="checkbox"/> Illnesses	<input type="checkbox"/> Medications

Previous pregnancies by mother, miscarriages, complications? _____

Any significant medical problems with other children? _____

Birth & Development History

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

Length of labor _____ Complications? _____

C- section? _____ Vaginal Birth? _____

Did your child have any of the following problems shortly after birth?

<input type="checkbox"/> Jaundice	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Seizures
<input type="checkbox"/> Colic	<input type="checkbox"/> Projectile Vomiting	<input type="checkbox"/> Birth Defect
<input type="checkbox"/> "Blue Baby"	<input type="checkbox"/> Fever	<input type="checkbox"/> Birth Injuries

Breast Fed? _____ How long? _____ Formula? _____ What kind? _____

Age began solid foods _____ What were the first foods introduced? _____

Food Intolerances (if any)/ Allergies _____

Daily Routines: Meal _____

Play _____

Rest _____

Sleep Pattern: Nightly sleep (hours) _____ Activity in Sleep _____

Naps # _____ How long? _____

Developments: Sitting _____ Crawling _____ Walking _____

Babbling _____ First Words _____ Sentences _____

Fresh air & outdoor activity (hours) _____ TV/ Computers/ Other electromagnetic stress _____