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Pickering Chiropractic Health Center
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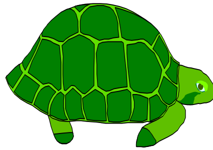

Pediatric Intake Form

Name________________ D.O.B___________________ Ethnicity: _______________

Gender_______________ Height (cm): _________ Weight (lbs.): ________

Parent/Guardian Name(s): ____

Address: ____

City: _____________________ Province: ________ Postal Code: _______________

Telephone: (H)____________________ (W) _____________________

Family Physicians Name: ____________________

Address: ____

City: _____________________ Province: ________ Postal Code: _______________

Telephone: (H)____________________ (W) _____________________

Emergency Contact Numbers (other than parent/guardian)______________________
____
____

Chief Complaint(s)/Concern(s)

____
____

Family History

Any major health concerns in the family (biological parents, grandparents, and family)? i.e. Heart disease, Diabetes, etc.

____
____

Prenatal History

1. Age of mother and father at onset of pregnancy? ___________________________
2. Is/was this your first pregnancy? (if not please indicate number if pregnancies)
   ____
3. Any prior miscarriage(s)? ____
4. Any history of infertility? ____
5. Any fertility medications used?
   (indicate)____
   ____
6. Amount of weight gained during pregnancy? _______________________________
7. Any symptoms experienced during pregnancy such as nausea, vomiting, and food cravings etc. ____
8. Any infections, illnesses or complications during pregnancy? (if yes, please specify) If so, how were they treated?
   ____
   ____
9. Travel history (Did you travel during or anytime before your pregnancy, if yes, please specify)
   ____
   ____
10. How was your diet and appetite during pregnancy? Please list the typical foods consumed during your pregnancy.
    ____
    ____
    ____
    ____
11. Were you ever exposed to the following during your pregnancy?

Alcohol	
Recreational Drugs	
Smoke	
Stress, Trauma	
Medications (if so please specify)	
Supplements	
Heavy Metal (paint chips etc)	

Natal History

Duration of pregnancy
Full term_____ Premature (if so how many weeks)__________ Late_________

Birth Weight (lbs.) _________ Birth Length (cm)___________
Head Circumference (cm) ___________

How long was the labor? ____

Where there any medications administered prior to delivery? (If so, specify)____

Type of delivery

Vaginal	
C-section	
Suction	
Forceps	
Induced	

Any complication experienced? (If so, please specify)
____
____

Nutrition and Feeding

Was the child breastfed? (If so, for how long) ________________________________

Formula Fed? ___________ How long______________ Which Formula ___________

Any reaction or difficulty feeding? ____

What was the time of food introduction and what type? (Please indicate time of introduction)

Time of Introduction (month)	**Type of food**

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Does your child have any food allergy(s) and/or intolerance (s)? (Please indicate)

____

____

What are their eating habits like? ______________________________

Dietary Restrictions______________________________

Supplements? ______________________________

Medical History

Vaccination Record

Type	Date	Reactions
DPT		
HiB		
MMR		
Polio		
Hepatitis B		
Varivax		

Any major accident(s) and/or hospitalization(s)? (Please indicate date and what for)

____

____

____

Does your child have any medical conditions? If so, are they currently on any medication(s) for it?

____

____

Childhood Illnesses

Type	Date
Chicken pox	
Measles	
Fifth Disease	
Croup	
Whooping cough	

Ear infections	
Other	

Dental History

Is your child currently seeing a dentist? ________________________

Name of dentist________________________ Phone Number ________________________
Address____
____

Is your child teething currently? ______________________ And when did it start____

When did their first teeth appear?
____

How many teeth do they currently have____?

Any cavities? (If so, how many and what type of filling)
____

Any bleeding gums or other dental concerns?
____

Developmental Milestones

Development	Age
Smile	
Sits with support	
Sits up (independent)	
Crawled	
Walked	
Talked	
Teething	
Potty trained	

Social History

With whom does your child live with?
____

What is the living environment like? ____

How is the home heated? ____

Water source (well, tap, filtered etc)____

Is your child exposed to the following?

Tobacco	
Heavy metals	
Alcohol	
Molds, fungus	
Chemicals	
Pets	

Is violence a concern in the home? ____

Is your child currently in school? ______ Day Care__________ Home__________

What grade is your child in? ____________

Any learning difficulties? (If so, please specify)____
____

Extracurricular activities? (Please list)
____
____

Do they have playmates?____

How is your child's sleep? ______________ How many hours? __________________

Naps? ____________________ How is their energy level? ______________________

How is their activity level? ____

How is temperament? ____

Average number of hours of TV and/or computer exposure? ____________________

Adolescence

Are you in school? _________ Current grade ________________

What extracurricular activities do you participate in?
____
____

Tobacco use? __________ Frequency _______________ Amount ______________

Alcohol use? __________ Frequency _______________ Amount ______________

Recreational drug use? If so, please list type used____
____

Frequency ____________ Amount ______________

Are you sexually active? ________________ Are you practicing safe sex? _________

Describe your home environment.
____
____

What is your sexual identity? ____

Have you ever experienced abuse in any form? ______________________________

24 hour diet recall (please list foods you have eaten in the past 24 hours)

Breakfast	**Lunch**	**Supper**	**Snacks**	**Drinks**

Females (complete this section)

Age of first menarche (period) ____

Duration of cycle _________ Duration of flow _____________

Last known menstrual period ________________________________

Tampons? _________ Pads? ________________ Other, indicate ________________

Average number used per day during period (tampons, pads, etc)______________________

Characterize your period (circle): heavy light

Do you experience any PMS (such as breast tenderness, cramps, and irritability)?
____
____

Do you notice clotting?
____

Are you on the birth control pill? _________________ Specify brand _______________

How long have you been on it? ____

Consent

I ________________________ hereby acknowledge that the above information is accurate
Parent/guardian

to the best of my knowledge, and I hereby consent to treatment for my child
________________.

____
Date

____
Print Name

____
Signature