Pediatric Intake Form

Please fill out this form and email it to drbitner@ndoc.ca.

Note: If fonts are not loading in Acrobat, please open this form in your web browser.

Today's Date:

Name:

Birth Date: Gender:

Guardian Name: Relationship:

Address: City: Province:

Postal Code: Email:

Home Phone: ( ) Work Phone: ( ) Cell: ( )

Preferred Method of Contact: ☐ Home ☐ Work ☐ Cell ☐ Email

Whom does the child live with?

What are the child's health concerns, in order of importance?

1.
2.
3.
4.
5.

Medical History

How would you describe your child's general state of health? (please check)

☐ Excellent ☐ Good ☐ Fair ☐ Poor

How would you describe your child's energy level? /10 (0 = no energy, 10 = an abundance of energy.

Please indicate any serious condition, illnesses or injuries, and any hospitalizations/surgeries along with approximate dates:

Which of the following has your child had?

☐ Rubella	☐ Mumps	☐ Whooping cough	☐ Mononucleosis
☐ Measles	☐ Roseola	☐ Strep throat	☐ Ear infections
☐ Chicken pox	☐ Scarlet fever	☐ Impetigo	☐ Herpes Simplex

Has there been a significant gain or loss of weight? ☐ Y ☐ N

Has there been a failure to gain weight appropriate to the child's age? ☐ Y ☐ N

Does your child have any allergies (medicines, environmental, etc.). If yes, please record reaction to allergen (rash, itching, runny nose, watery eyes, difficulty breathing, etc.)?

Does your child have any food allergies and/or intolerance? Please list food item and reaction to allergen.

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.). Please list dose, frequency, and brand name.

Please list past prescription medications.

How many times has your child been treated with antibiotics?

Please indicate the immunizations your child has had; please indicate date(s) of immunizations:

☐ DPT (diphtheria, pertussis, tetanus)		☐ Flu	
☐ Tetanus booster		☐ Polio	
☐ MMR (mumps, measles, rubella)		☐ Hepatitis B	
☐ Haemophilus influenza B		☐ Hepatitis A	

☐ Other?

Please indicate if any caused adverse reactions (for example, fever, rash, ear ache, behavioural disturbances, etc.) immediately or up to a month following vaccinations:

Family History

Please indicate if a close relative (grandparent, parent, sibling) has or has had any of the following and provide the relationship to the child :

Condition	Relationship	Condition	Relationship
☐ Alcoholism		☐ Hodgkin's	
☐ Allergies		☐ Hypertension	
☐ Arthritis		☐ Juvenile arthritis	
☐ Asthma		☐ Kidney disease	
☐ Autoimmune disease		☐ Learning disability	
☐ Blood disorder		☐ Mental illness	
☐ Birth defects		☐ Seizure disorder	
☐ Cancer		☐ Sickle cell anemia	
☐ Cardiovascular disease		☐ Stroke	
☐ Diabetes (I or II)		☐ Tuberculosis	
☐ Endocrine disease		☐ Other	

Do either of the parents/guardians and/or siblings have a chronic illness?

Grandparents' History:

	Alive/Deceased	Age (at death)	Major Health Conditions
Maternal grandmother			
Maternal grandfather			
Paternal grandmother			
Paternal grandfather			