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Confidential Child Intake Form

Please complete the following form in order to provide us with the background information we require to ensure you receive comprehensive care. It should take 15-20 minutes.

Personal Information

Child's Name _____ Date _____

Date of birth _____ Age _____ Gender: ❍ Male ❍ Female

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

Address _____ City _____

Province _____ Postal code _____

Phone: Home _____ Work _____ Other _____

Email _____

May we leave messages relating to your child's visit? ❍ Yes ❍ No

Other health care providers (Medical Doctor, specialists, etc.)

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Emergency contact person

Name: _____ Relationship: _____

Phone: _____ Alternate number: _____

How did you find out about Dr. Lisa Watson?

❍ Referral from _____ ❍ Chatelaine ❍ Today's Parent

❍ Internet search ❍ Global TV ❍ Other _____

Would you like to receive our seasonal newsletter with information on health and upcoming events? Your email address will not be shared. ❍ Yes ❍ No

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What are your child's main health concerns (in order of importance)?

1. _____
2. _____
3. _____
4. _____

Have any of these conditions recently changed or become worse?

_____

_____

Medical History

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

Please indicate any serious conditions, illnesses, injuries or hospitalizations along with approximate dates.

_____

_____

Does your child have any allergies or sensitivities (medicine, environmental, other)?

_____

_____

Please list all current medications, including dosage, duration of use and reason for use.

Medication	Dose	Duration	Reason/ condition treating

Please list all past prescription medications

_____

_____

Please list all natural health products (supplements, vitamins, herbs, homeopathics).

Natural Health Product	Dose	Duration	Reason/ condition treating

Please indicate which vaccinations your child has received

❍ DPT (diphtheria, pertussis, tetanus) ❍ MMR (measles, mumps, rubella) ❍ Influenza
❍ Haemophilus influenza B ❍ Hepatitis A ❍ Hepatitis B
❍ Tetanus booster; when? _____ ❍ Varicella (chicken pox) ❍ Other
❍ Any adverse reaction to an immunization? _____

Has your child had any of the following childhood illnesses?

❍ Chicken pox ❍ Mumps ❍ Scarlet fever
❍ Ear infections ❍ Pneumonia ❍ Tonsillitis
❍ Frequent colds ❍ Rheumatic fever ❍ Whooping cough
❍ Measles ❍ Rubella

Has your child ever used antibiotics? ❍ Yes ❍ No Date/ dosage/ duration: _____
For what condition? _____

Family History

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

❍ Alcoholism ❍ Depression ❍ Gallstones ❍ Osteoporosis
❍ Allergies ❍ Other mental illness ❍ Heart disease ❍ PMS
❍ Arthritis ❍ Diabetes ❍ High blood pressure ❍ Skin disease
❍ Asthma ❍ Drug abuse ❍ Kidney disease ❍ Stroke
❍ Cancer ❍ Endometriosis ❍ Multiple sclerosis ❍ Thyroid disease
(type _____) ❍ Epilepsy ❍ Obesity ❍ Tuberculosis

Perinatal History

What was the age of the mother at the child's birth? _____ Father's age? _____
What was the health of the mother at conception? ❍ Excellent ❍ Good ❍ Fair ❍ Poor
What was the health of the father at conception? ❍ Excellent ❍ Good ❍ Fair ❍ Poor
What was the health of the mother during pregnancy? ❍ Excellent ❍ Good ❍ Fair ❍ Poor
Was there any difficulty in conceiving? ❍ Yes ❍ No
Were there any complications during pregnancy (nausea, high blood pressure, toxemia, injuries, diabetes, etc.)? _____
_____

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Did the mother use any of the following during pregnancy? (Frequency, amount)

❍ Alcohol _____ ❍ Supplements _____

❍ Tobacco _____ ❍ Prescription drugs _____

❍ Over the counter medications _____

❍ Recreational drugs _____ ❍ Other _____

Birth History

Number of weeks gestation at birth: _____

Child's weight at birth: _____ Child's height at birth: _____

Delivery by: ❍ Vaginal birth ❍ Caesarean section, why? _____

Please check all interventions that apply to the birth:

❍ Epidural ❍ Induced labour ❍ Forceps

❍ Pitocin ❍ Other interventions _____

Were there any complications during or after delivery? ❍ Yes ❍ No If yes, please explain.

_____

_____

Did your child experience any of the following in the weeks after birth?

❍ Congenital birth defect ❍ Fever ❍ Feeding difficulties

❍ Infection ❍ Jaundice ❍ Skin conditions (cradle cap, eczema, etc.)

Feeding History

Was child breastfed? ❍ Yes, how long? _____

❍ No. What formula was used? _____

At what age was solid food introduced? _____

What foods were introduced first? _____

Does child have any food allergies or sensitivities? ❍ Yes ❍ No

_____

Does child have any dietary restrictions (vegetarian/ vegan, religious, etc.)? ❍ Yes ❍ No

_____

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Describe a typical day's diet for your child

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

Development

Current height _____ Current weight _____

At what age did your child reach the following milestones?

❍ Sitting up _____ ❍ Crawling _____ ❍ Walking _____

❍ First words _____ ❍ First teeth _____ ❍ Toilet training _____

Any concerns (parents, teachers, doctors) regarding child's growth and development?

_____

_____

Sleep

Does your child sleep through the night? ❍ Yes ❍ No ❍ Sometimes

Hours of sleep per night _____ Number of naps and length _____

Does your child have any sleeping problems (nightmares, bedwetting, etc.)? ❍ Yes ❍ No

_____

Lifestyle and Environment

Is your child currently in: ❍ School ❍ Daycare ❍ Homecare ❍ Other: _____

Is your child exposed to tobacco smoke at home or elsewhere? ❍ Yes ❍ No

Is your child frequently exposed to animals (pets, other)? ❍ Yes ❍ No

What are your child's hobbies or special interests? _____

_____

Does your child have any fears/ anxieties/ worries that you are aware of? _____

_____

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Describe your child's temperament/ behaviour. _____

_____

_____

How many hours a week does your child engage in the following activities

Activity	**Never**	**1-4 hours/wk**	**4-8hours/wk**	**More than 8 hours**
Watch TV	❍	❍	❍	❍
Play video games	❍	❍	❍	❍
Use the computer	❍	❍	❍	❍
Play sports	❍	❍	❍	❍
Exercise/ active play	❍	❍	❍	❍
Read (or read to)	❍	❍	❍	❍

Other organized time (e.g. piano or music lessons, etc.) _____

Is there anything else that you feel is important that has not been covered?

_____

_____

_____