



**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: <input type="radio"/> Male <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> 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



**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.)? \_\_\_\_\_

\_\_\_\_\_



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

- Alcohol \_\_\_\_\_
- Tobacco \_\_\_\_\_
- Over the counter medications \_\_\_\_\_
- Recreational drugs \_\_\_\_\_
- Supplements \_\_\_\_\_
- Prescription 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
- Pitocin
- Induced labour
- Other interventions \_\_\_\_\_
- Forceps

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
- Infection
- Fever
- Jaundice
- Feeding difficulties
- 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

\_\_\_\_\_



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? \_\_\_\_\_

\_\_\_\_\_



Describe your child's temperament/ behaviour. \_\_\_\_\_

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

<b>Activity</b>	<b>Never</b>	<b>1-4 hours/wk</b>	<b>4-8hours/wk</b>	<b>More than 8 hours</b>
Watch TV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Play video games	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Use the computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Play sports	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise/ active play	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Read (or read to)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

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

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