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PEDIATRIC INTAKE FORM

Please complete this form and return it on your first visit

Name: _____ Date: _____

Address: _____

Telephone numbers: (h) _____
(w) _____
May we leave messages for you at these numbers? ___ YES ___ NO

E-mail: _____

Referred by: _____

Family Medical Doctor _____

Other Primary Care Givers _____

Emergency Contact

**THE FOLLOWING INFORMATION IS CONFIDENTIAL AND WILL NOT
BE RELEASED WITHOUT YOUR WRITTEN PERMISSION**

Child's name _____ Date of birth _____ Sex M F
Date _____ Who is filling out this form (name and relation)? _____

Whom does the child live with(all family members) _____

What are your 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? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates:

Which of the following has your child had? (n – never, m – mild, a – average, s – severe)

n m a s rubella (german measles)	n m a s roseola	n m a s impetigo
n m a s measles	n m a s scarlet fever	n m a s mononucleosis
n m a s chicken pox	n m a s whooping cough	n m a s ear infections
n m a s mumps	n m a s strep throat	

Does your child have any allergies (medicines, environmental, etc.)?

Please list all current medications (prescription, over-the-counter, vitamins, herbs, etc.)

Please list past prescription medications.

How many times has your child been treated with antibiotics? _____

Please indicate what immunizations your child has had

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus) | <input type="checkbox"/> Haemophilus influenza B | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Tetanus booster; when? _____ | <input type="checkbox"/> "Flu" | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> MMR (measles, mumps, rubella) | <input type="checkbox"/> Polio | |
| Other _____ | | |

Please indicate if any caused adverse reactions

What screening tests has your child had (blood, hearing, vision, etc.) _____

Prenatal health

What was the health of the parents at conception?

Mother	Poor	Fair	Good	Excellent	Unknown
Father	Poor	Fair	Good	Excellent	Unknown

What was the health of the mother during the pregnancy?

Poor	Fair	Good	Excellent	Unknown
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What was the mother's age at child's birth? _____

How was the mother's diet during pregnancy?

Poor	Fair	Good	Excellent	Unknown
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Did the mother receive prenatal medical care? Y N Unknown

Did the mother experience any of the following during the pregnancy:

- | | | | |
|-----------------------------------|--|---|-----------------------------------|
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Physical or emotional trauma | |

Other _____

Did the mother use any of the following during the pregnancy?

Tobacco Alcohol Recreational drugs: _____

Prescription medications:

Over-the-counter medications:

Supplements:

Other:

Birth history

Term length: Full Premature: _____ wks Late: _____ wks

Length of labour: _____ Weight at birth _____

Any complications?

Was the birth: Vaginal/C-section Induced Forceps Anesthesia used

Did the child experience any of the following at or shortly after birth?

Jaundice Rashes Seizures Birth injuries

Birth defects

Other

Diet

How was your infant fed?

Breast fed. How long? _____ Formula. Milk/Soy/Other: _____

Other: _____

What foods were introduced before 6 months? (Please list approximate month as well.)

6–12 months?

Did your child ever experience colic? Y N How severe? mild moderate severe

Does your child have any food allergies or intolerances? Please list.

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)?

Health and Development

How was your child's health in the first year? Poor Fair Good Excellent Unknown

At what age did your child first

Sit up _____ Crawl _____ Walk _____ Talk _____

Describe your child's sleep pattern _____

How would you describe your child's temperament? _____

How would you describe your child's behaviour and performance at school?

Environment

Is the child in school daycare home care other _____

What are your child's favorite activities? _____

Does the child exercise regularly? Y N How much, how often?

How much television does your child watch? _____ hrs a day/week

How often does your child read (not for school), or How often does someone read to your child?

Daily Several times a week Weekly Less than weekly

How would you describe the emotional climate of the child's home?

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

