TRI·HEALTH
WELLNESS CENTRE

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CHILD INTAKE FORM

PLEASE COMPLETE THIS FORM AND RETURN IT TO CLINIC RECEPTION

(PLEASE PRINT CLEARLY)

Today's Date (dd/mm/yyyy) _______/_______/_____

Child's name: ______________________________ Nickname: _____________________

Date of birth: _______________ Age: ______ Sex (please circle one): M F

Form filled in by & accompanying child (and relation to child): _____________________

____

Address: House/Apt.# & Street: ____

City: ______________________ Province: _________________ Postal Code: ________

Phone Number: (____)______-_________ E-mail: ________________________________

Referred by: ____

Other Doctors/practitioner(s):

1. Name: ___________________________ Phone number: (____)______-_________

Address: ____

2. Name: ___________________________ Phone number: (____)______-

________ Address:

____

Emergency Contacts: (please list in order of preference)

1. Name: ________________________ Relation to child: ________________

   Address: ____

   Phone number: (home) (____)______-_________

   (work) (____)______-_________

   (cell) (____)______-_________

2. Name: ________________________ Relation to child: ________________

   Address: ____

   Phone number: (home) (____)______-_________

   (work) (____)______-_________

(cell) (____)______-________

CURRENT INFORMATION: Height: ____________ Weight: _______________

Please list all current medications: *(include prescriptions, over-the-counter, vitamins, herbs, homeopathics etc)* ____

____

Ethnicity: (*optional)* _________________

Whom does the child live with?: ____

CHILD'S CHIEF HEALTH CONCERNS: (please include all applicable details, and date of onset)

HEALTH CONCERNS→	**1)**	**2)**	**3)**	**4)**	**5)**
When did it start?					
Intensity (10 is the worst)					
How long does it last?					
How often does this occur?					
Location:					
Any associated symptoms?					
What makes it better?					
What makes it worse?					
Current Treatments & Medications:					

PAST MEDICAL & SURGICAL HISTORY

Hospitalizations *(includes trauma and/or injuries):*

Reason (include symptoms)	Age	Findings	Length of Stay	Treatments (medications)
1)				

2)				
3)				

Illnesses & Infections:

Infection:	Age at Onset	Frequent/ Recurring (indicate how often)	Chronic	Treatment
Otitis media (ear infections)				
Sinusitis (sinus infections)				
Pneumonia				
UTI				
Asthma				
Eczema				
Neoplastic disorder				
Genetic disorder(s)				
Behavioural Disorder(s)				
Rubella				
Measles				
Chicken pox				
Mumps				
Roseola				
Scarlet fever				
Whooping cough				
Strep throat				
Impetigo				
Mononucleosis				
Others:				

IMMUNIZATIONS-include date: *(or you may attach a photocopy of your records)*

☐ "Flu" ☐ Polio ☐ MMR (measles, mumps, rubella)
☐ Haemophilus influenza B ☐ Hepatitis A ☐ Hepatitis B
☐ DPT (diphtheria, pertussic, tetanus) ☐ Tetanus, booster
☐ Varicella/chickenpox ☐ Other(s):____
Adverse reactions: ____
____

ALLERGIES: (including foods, environmental, medications):
____

____

PRENATAL HISTORY (INFORMATION OF MOTHER DURING PREGNANCY):

Describe mother's health at time of conception: Excellent / Good / Fair / Poor / Unknown
Describe father's health at time of conception: Excellent / Good / Fair / Poor / Unknown
Describe the mother's health **during pregnancy**: Excellent / Good / Fair / Poor
Illnesses/Infectious diseases:____

Use of: *(please indicate amounts & frequency)*
☐ Tobacco ☐ Alcohol ☐ Recreational drugs:___________________________________
☐ Prescription medications: ____
☐ Over the counter medications: ____
☐ Supplements: ____
☐ Other: ____
Age at delivery:_____

Complications:

☐ High blood pressure ☐ High blood sugar ☐ Water retention
☐ Bleeding/spotting ☐ Thyroid problems ☐ Nausea
☐ Vomiting ☐ Physical trauma ☐ Emotional trauma
☐ Other: ____
Food cravings (include frequency of consumption): _________________________________
____
Please list a typical day's diet for mother during pregnancy (include snacks):
____
____
____
Occupation during pregnancy (list full or part-time): ______________________________

Birth History:

Length of pregnancy:
☐ Full-term______weeks ☐ Premature:______weeks ☐ Late:________weeks
Duration of labour:_______hours
Complications: ____
____

Type of delivery:

☐ Spontaneous ☐ Forceps/Suction ☐ Caesarean section
☐ Anesthesia used ☐ Natural ☐ Induced
APGAR scores: @ 1 minute:______ @ 5 minutes:______
Birth weight: ____lbs ____oz. (______kg) Birth length:___________
Head circumference: _____________
Did the child experience any of the following at or shortly after birth?
☐ Birth injuries ☐ Jaundice ☐ Rashes
☐ Seizures ☐ Other: ____

<u>Newborn History:</u>
List any illnesses or congenital abnormalities discovered at birth:
____
Did the child require any resuscitation, procedures or interventions at birth:
____
Length of hospital stay:__________ Weight at discharge:______lbs______oz.

<u>Growth and Development:</u>
Age of Developmental Milestones: Crawling_______ Walking_________
Talking________ Washroom training (urinary)_____________, (bowel)__________

<u>Additional Adolescent Information (for patients ages 9-13 only):</u>

<u>General Care</u>:

Diet *(please list a typical day's diet, including all fluids & snacks):*

____

____

____

____

____

Hours of sleep per night: _____ Sleeps at what time?: ______Awakes at what time?: _____

Exercise (please include type and number of sessions per week):

____

Hobbies:

____

Dental History:

____

Drug/cigarette/alcohol use: (please include amount per day or week –OR- list "None")

____

Is there anything additional that you feel is important? Please list and describe:

____

____

____