**Paediatric Intake**

Child’s name: Date of birth: Age:

Sex:

Date Referred by Who is filling out this form (name and relation)?

**Contacts** (in order of preference):

Name Address

Phone

(H)

(W)\_

(Mob)\_ Relationship to child

Name Address

Phone

(H)

(W)\_

(Mob)\_ Relationship to child

With whom does the child live?

How did you hear about Well Woman Family Acypuncture?

Please list the child’s other health care providers:

|  |  |  |
| --- | --- | --- |
| 1. | 2. | 3. |
| Name| | Name| | Name| |
| Practice type| | Practice type| | Practice type| |
| (\_ )\_ | (\_ )\_ | (\_ )\_ |

What are your child’s health concerns, in order of importance:

1.

|  |  |
| --- | --- |
| 2. |  |
| 3. |  |
| 4. |  |

**Medical History**

How would you describe your child’s general state of health? Excellent Good Fair Poor

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

Which of the following infections has your child had, and how severely were they affected?

(n = never, m = mild, a = average, s = severe) \**immunizations/vaccines do not apply here*

**rubella (german measles)**

n m a s **measles**

n m a s **chicken pox**

n m a s **mumps**

n m a s

**whooping cough (pertussis)**

n m a s **strep throat**

n m a s **impetigo** n m a s

**Roseola**

n m a s

**mononucleosis** n m a s **ear infections**

n m a s **other:**

**Please print, complete, and fax forms prior to your initial appointment. Thank you.**

Please indicate what immunizations (vaccines) your child has had:

 DPT (diphtheria, pertussis, tetanus)  Haemophilus influenza B  Hepatitis B

 Tetanus booster; when?

 “Flu”  Hepatitis A

 MMR (measles, mumps, rubella)  Polio  Chicken pox

 Meningococcus  Other:

Please indicate any adverse reactions to the above vaccines, with detail:

Does your child have any allergies (medicines, environmental, food etc.)? If yes, please explain:

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

Please list past prescription medications, and dosage if known:

How many times has your child been treated with antibiotics?

What screening tests has your child had (blood, hearing, vision, etc.)? Please list:

**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 What was the mother’s age at child’s birth?

How was the mother’s diet during pregnancy? Poor Fair Good Excellent Unknown

Did the mother receive prenatal medical care? Y N Unknown

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

|  |  |  |  |
| --- | --- | --- | --- |
|  Bleeding |  High blood pressure |  Nausea  Vomiting |  Unknown |
|  Diabetes |  Thyroid problems |  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 during labour? Was the birth (circle all that apply): 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  Brain injuries

 Other

**Diet**

How was your infant fed?

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

What foods were introduced before 6 months?:

6–12 months?

Did your child ever experience colic? Yes No How severe? mild moderate severe

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

Did your child hit each of the appropriate milestones (crawling, sitting, etc.)? Yes No

If no, please explain: Describe your child’s current sleep pattern:

How would you describe your child’s temperament?

**Family History**

Please fill out any known medical conditions for the family members indicated on the following tree:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Maternal Grandmother | Maternal Grandfather |  | Paternal Grandmother | Paternal Grandfather |
|  | Mother | Father |  |
| Siblings | | Child | Siblings | |

**Environment**

Is the child in (circle all that apply): school daycare home care other:\_ What are your child’s favorite activities?

Does the child exercise regularly? Yes No 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

Does anyone in the child’s household smoke? Yes No

Are there animals in the home? Y N

Do you know of any toxins or other hazards the child is regularly exposed to (home, other’s work, hobbies, etc.)? Please describe.

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?