360° Health Care

health care

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 360 Health Care?

❍ Referral from _____ ❍ Chatelaine ❍ Today's Parent

❍ Internet search ❍ Yellow Pages ❍ 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.)? _____

_____

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

_____

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. _____

_____

_____

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?

_____

_____

_____