VIRIDITAS CLINIC

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CONFIDENTIAL PEDIATRIC INTAKE FORM

Today's Date: _____

Name: _____
Age _____ Date of Birth _____/_____/_____ Gender: ___ Female ___ Male
Mother's Name: _____ Father's Name: _____
Address _____
City _____Province_____ Postal Code _____
Telephone # Home: _____ Parent's Work: _____
May we leave a message at home? YES/NO May we leave a message at work? YES/NO
Child lives primarily with (circle): • Both parents • Mother • Father • Other? _____

In case of emergency notify:_____Telephone #: _____
Family doctor: _____
What is your child's blood type? A B O AB
Has your child ever had an anaphylactic allergic reaction? YES/NO
To what substance? _____
How did you hear about this clinic?
_____

Main Reason (s) for visit? (Diagnosis, Chief Complaints & Symptoms)
List as many as you can in order of importance.
1) _____ length of time :_____
2) _____ length of time :_____
3) _____ length of time :_____
4) _____ length of time :_____
5) _____ length of time :_____
Other Health Issues: _____
Does your child have a contagious disease at this time? YES/NO

TRAUMAS, ACCIDENTS, HOSPITALIZATIONS, SURGERIES

	Date	What Happened?	Outcome?	Comments?
1)				
2)				
3)				

ALLERGIES
Is your child hypersensitive or allergic to (food, drugs, environment?)
_____
_____

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FAMILY HISTORY

Please circle if there is any history of the following conditions in your family:

allergies alcoholism Alzheimer's disease ankylosing spondylitis asthma
cancer depression diabetes drug abuse eczema
heart disease high blood pressure kidney disease mental illness
multiple sclerosis osteopoerosis psoriasis rheumatoid
arthritis thyroid issue Other: _____

PREGNANCY HISTORY

Were there any difficulties during pregnancy? YES/NO
Please circle any difficulties experienced during pregnancy:
gestational diabetes thyroid condition emotional trauma nausea/vomiting
physical trauma high blood pressure toxemia bleeding
threatened miscarriage Other:_____
Was the birth process natural? YES/NO Were there any complications? _____
Were there any interventions during the birth? (ie. forceps, medications, epidural, induction, c-section, etc..)
_____
Were there any problems after the birth? _____

HEALTH HISTORY

Was your child breastfed? YES/NO How long? _____
Any vomiting of mother's milk? YES/NO Was formula used? YES/NO
How long? _____ Was it soy formula? _____
What foods were introduced first? _____ When? _____
Any reactions to foods introduces? Please describe: _____
When was cow's milk introduced? _____
Is there anything that you exclude from your child's diet? _____
Is your child a picky eater? If so, please explain: _____
Does your child have any particular food likes or dislikes? _____
How much does your child drink? _____ What do they drink? _____

When did your child achieve developmental milestones? please circle: early average late
How many hours of sleep does your child get per night? _____ Is it restful? _____

Does your child routinely receive medications to lower fever if there is a fever? YES/NO
How many times has your child received a course of Antibiotics? _____
Are there any behavioural issues that are a concern for you? _____
Any significant fears? Night terrors? Please explain: _____

MEDICATION/SUPPLEMENTS

Please list any prescription medications, over the counter medications, vitamins or other supplements your child is taking.

1) 5)
2) 6)
3) 7)
4) 8)

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PREVIOUS ILLNESSES

Please circle if there is any history of the following conditions:

allergies	asthma	bedwetting	bladder infections
bronchitis	cavities	chicken pox	chronic nasal congestion
clotting defects	colic	constipation	cradle cap
ear infections approx. number ___		epilepsy	excessive perspiration
failure to thrive	fecal incontinence	frequent colds	frequent strep throat
gas/bloating	thrush	german measles	growing pains
heart murmur	hepatitis	insomnia	jaundice
joint problems	measles	mono	motion sickness
mumps	night terrors	Parasites/worms	pneumonia
polio	rashes	rheumatic fever	rubella
stomachaches	tonsillitis approx. number ___		whooping cough

Other: _____

Has your child had any of the following tests? When? Where? Result?

Electroencephalogram (EEG) _____ Psychological evaluation _____

Hearing tests _____ Speech/Language tests _____

IMMUNIZATIONS

Please circle if your child has had any of the following vaccinations:

Polio Pertussis Tetanus shot Measles/ Mumps/Rubella
Influenza Diphtheria

Any adverse reactions? YES/ NO If yes, please describe: _____

TYPICAL FOOD INTAKE

Breakfast:_____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Thank you for your time and effort. We look forward to providing you with the best possible care. If there is anything else you would like to add at this time please do so on the rest of this page.

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