Paediatric Intake Form (Birth to 12 years)

Date_____

Child's name_____DOB__/__/__ Sex M/F Height___Weight___ Age of Child____
Parent's/Guardian's Names_____
Telephone (h)_____ (c)_____(w)_____email_____
Address_____
Has your child ever been to a chiropractor before? Y/N Name of Dr_____
Were x-rays taken? Y/N
Who is your family doctor/paediatrician?_____Date and reason of last visit_____
Purpose of today's visit_____
How did you hear about our office? _friend _phonebook _sign _website _other
BC Health Care Card Number_____

Prenatal History
Is your child adopted? Y/N
Did you have any complications and when?_____
Did you smoke/consume alcohol? Y/N
Did you take medication? Y/N Reason_____

Birth History
Did you have ultrasounds during this pregnancy? Y/N Frequency_____
Place of birth: Home/Birthing Centre/Hospital
Provider: Midwife/OB-GYN/Other_____
Type of Birth: Vaginal/C-Section Were pain medications used? Y/N Type_____
Was labour induced? Y/N If yes, why?_____
What position did you deliver in? Squatting/On Back/Other_____
Birth Trauma: Doctor assisted/Twisting/Pulling/Vacuum Extraction/Forceps
Newborn Trauma (medical procedures and tests):_____
APGAR score: at birth___/10 at 5 mins___/10 Unsure
Did your child have a misshaped skull/head? Y/N Purple markings on their face? Y/N
Birth weight_____ Birth length_____
Jaundice (yellow) at birth?____Cyanosis (blue) at birth?_____
Congenital anomalies/defects?_____

Feeding
Infant Feeding: Breast___ Bottle___ Formula___
Do you/Did you breastfeed your child? Y/N If yes, for how long?_____
Does your child prefer one breast/side over the other? Y/N Side: Right/Left
Does your child have any food or other allergies? (list)_____

Immunizations
Has your child been immunized according to the recommended schedule? Y/N
Did your child have negative reactions to vaccinations? Y/N_____
Were they reported? Y/N

Sleep

Number of hours your child sleeps daily_____

Quality of sleep: Good___Fair___Poor___Explain_____

Medical History

Has your child ever had any surgeries? Y/N Explain_____

Have they been on antibiotics? Y/N How many times?____ Reason_____

Is your child currently taking any medications? Y/N (list)_____

Any vitamins/supplements?_____

Has your child ever been treated on an emergency basis? Y/N Describe_____

Are there any illnesses that run in your family?_____

Childhood Diseases: Age of child when occurred?

___Chicken Pox ___Rubella (German Measles) ___Mumps ___Other

___Whooping Cough ___Rubeola ___Measles

Developmental History: At what age did your child?

___Respond to sound ___Crawl

___Follow an object with their eyes ___Stand

___Hold head up ___Walk alone

___Sit alone

Baby/Toddler (0-4): Did any of the following occur?

_Fall from a changing table _Frequent crying spells _Sleeping problems

_Tumble down stairs _Frequent fevers _Colic

_Fall out of crib _Frequent ear infections _Repeated colds or infections

_Fall off playground equip _Tonsillitis _Reactions to vaccines

_Hit head _Frequent bouts of diarrhea _Inadequate weight gain

_Play in Jolly Jumper _Constipation _Other_____

_Car accident

Child (5-12): Have/did any of the following occur?

_Fall from a tree _Hyperactivity/autism _Stomach pains

_Fall off of a bicycle _Learning difficulties _Bed wetting

_Fall on playground _Behavioural problems _Leg/knee pains

_Car accident _Allergies _Scoliosis

_Sports accident _Asthma _Other_____

Which of the above bothers your child the most?

When did it begin?_____ Is it getting worse? Y/N

Is the pain?: constant/intermittent/cyclic

How much has the complaint affected daily activities/routines? not at all/somewhat/frequently/always

Which sports does your child play? _____

How would you rate your child's diet?

_Well balanced _average _high amounts of sugar & processed food

Is there anything else we should know about your child?_____