Kinesis Health Associates

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Pediatric/Youth Intake Form

Date: DD/MM/YYYY

Child's Full Name: _____ Sex: □M □F

Date of Birth: DD/MM/YYYY Preferred Pronoun: □ He □ She □ Other_____

Address: _____ Phone (Home): _____

_____ Phone (Cell): _____

_____ Phone (Work): _____

May we leave messages related to your visit? □Yes □No, Which number? _____

Email Address: _____

Name of Parent or Guardian filling out this form: _____

Relation to Child: _____

Emergency Contact (if different from above): _____

Relation: _____ Phone Number: _____

Whom does the child live with (Please list all family members): _____

_____

_____

Family Doctor's Name: _____ Phone Number: _____

Other Health Care Providers your child is seeing:

1. Name: _____ Specialty: _____
   Date of last visit: _____ Phone: (____)_____
2. Name: _____ Specialty: _____
   Date of last visit: _____ Phone: (____)_____
3. Name: _____ Specialty: _____
   Date of last visit: _____ Phone: (____)_____

Have you ever consulted for your child (Please check all that apply):

□ Naturopathic Doctor □ Acupuncturist □ Nutritionist □ Counsellor

Please list your child's health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Please indicate which immunizations your child has had:

□ DPT (Diphtheria, Pertussis, Tetanus) □ Tetanus booster, Date: _____

□ MMR (Measles, Mumps, Rubella) □ Polio □ Small Pox

□ Haemophilus Influenza B □ Hepatitis A □ Hepatitis B

□ Annual Flu Shot □Other:_____

What screening tests has your child had (blood, vision, hearing, etc.)

_____

_____

Medical History

How would you describe your child's general state of health?

□ Excellent □ Good □ Fair □ Poor

Please indicate any diagnoses, serious conditions, illnesses, or injuries your child currently or previously had, as well as any hospitalizations, along with approximate dates:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Does your child have any allergies (medications, dietary, environmental, etc.)?

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Please list all <u>current</u> medications/supplements/natural health products (including over-the-counter medications, herbs, vitamins, etc.) that your child is taking, along with dosing:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Please list any <u>past</u> prescription medications or supplements/natural health products that your child has taken:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

How many times has your child been treated with antibiotics?: _____

Has your child ever had any of the following?:

☐ Rubella (German Measles)	☐ Roseola	☐ Impetigo
☐ Scarlet Fever	☐ Infectious Mononucleosis	☐ Chicken Pox
☐ Whooping Cough	☐ Ear Infections	☐ Mumps
☐ Strep Throat		

Prenatal Health

What was the health of the parents at conception:

Father: ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Unknown

Mother: ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Unknown

What was the health of the mother during pregnancy?

☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Unknown

How was the mother's diet during pregnancy?

☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Unknown

Did the mother receive pre-natal care? ☐ Yes ☐ No ☐ Unknown

Did the mother experience any of the following during pregnancy?

☐ Bleeding/Spotting ☐ High Blood Pressure ☐ Nausea ☐ Vomiting

☐ Diabetes ☐ Thyroid Problems ☐ Physical/Emotional Trauma ☐ Unknown

☐ Other: _____

Did the mother use any of the following during pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational Drugs

☐ Prescription Medications (please list): _____
☐ Over-the-counter Medications (please list): _____
☐ Supplements (please list): _____
☐ Other: _____

Birth History

Term Length: ☐ Full Term ☐ Premature: _____/weeks ☐ Late: _____/weeks
Length of Labour: _____ hours Child's Birth Weight: _____
Please describe any complications that arose during labour/delivery: _____
_____

Was the birth: □ Vaginal Delivery □ Scheduled C-Section □ Emergency C-Section
□ Induced □ Forceps □ Anesthesia Used

Did the child experience any of the following at or shortly after birth:
□ Jaundice □ Rashes □ Seizures □ Birth Injuries □ Birth Defects

□ Other: _____

Was your infant fed: □ Breastmilk □ Formula □ Combination of Both

□Milk/Soy/Other: _____ For how long: _____

What foods were introduced before 6 months? (Please include approximate month):

_____
_____
_____
_____

What foods were introduced from 6-12 months? (Please include approximate months):

_____
_____
_____
_____

Health and Development

How was your child's health in the first year?
□ Poor □ Fair □ Good □ Excellent □ Unknown

Did your child ever experience colic? □ Yes (□ Mild □ Moderate □ Severe) □ No

At what age did your child first:

Sit up: _____ Crawl: _____ Walk: _____ Talk: _____

Describe your child's sleep patterns: _____
_____

Describe your child's temperament: _____
_____

Describe your child's behaviour/performance at daycare/school/home: _____
_____

Environment

Is the child in: □ Daycare □ Homecare □Pre-School □ Other: _____

List your child's favourite activities: _____
_____

Describe the emotional climate of the child home(s): _____
_____

Does anyone in the child's household smoke? □Yes □No

Is there anything else that you feel is important that has not yet been covered? _____

_____

_____

Review of Systems

(circle all that apply)

Skin
Eczema
Psoriasis
Hives
Dryness
Itching
Bruising
Rashes
Moles
Hair & Nails
Recent Loss
Change in Texture
Nail Infections
Abnormal Hair Growth

Eyes
Blurring
Tearing
Discharge
Itching
Redness
Pain

Ears
Pain
Discharge
Recurrent Infections
Ringing
Excessive Wax
Hearing Loss
Nose & Sinus Discharge

Mouth & Throat
Sore Throat
Bleeding Gums
Toothache
Sores
Hoarseness
Altered Taste
Tonsillectomy

Neck
Pain
Stiffness
Swollen Lymph Nodes
Goitre

Breast
Pain
Swelling
Lumps/Masses
Discharge
Rash

Axillae/Armpit
Tenderness
Swelling
Lumps/Masses
Rash

Lungs
Chest Pain on Breathing
Wheezing
Shortness of Breath
Cough
Phlegm
Asthma
Bronchitis
Frequent Colds/Flu

Heart/Chest
Pain
Palpitations
Blue Skin
Swelling
Urinating at Night
High Blood Pressure
Heart Murmur

Vascular
Cold Limbs
Numbness
Tingling
Leg Swelling
Discolouration of Extremities
Varicose Veins
Blood Clots
Leg Ulcers
Pain in Legs

GI Tract
Heartburn
Constipation
Diarrhea
Hemorrhoids
Blood in Stool
Use of Antacids
Use of Laxatives
Jaundice
Appendicitis
Colitis
Surgeries

Musculoskeletal
Joint Pain
Joint Swelling
Joint Stiffness
Back Pain
Muscle Pain

Neurological
Seizure
Black Outs
Stroke
Muscle Weakness
Tic/Tremor
Paralysis
Numbness
Dizziness
Mood Swings
Depression

Blood
Bleeding
Swollen Glands
Anemia
Exposure to Radiation
Blood Transfusion

Endocrine
Frequent Urination
Excessive Thirst
Fatigue
Intolerant to Cold
Intolerant to Heat
Sweating
Night Sweats
Nervousness

Genitourinary
Urinary Tract Infections
Kidney Stones
Pain on Urination
Blood in Urine