

Dr. Dorothy Fairley
PEDIATRIC INTAKE FORM

Date: _____

Child's name: _____ Age: _____ Sex: _____

Birth Date: _____ Mother's name: _____ Father's name: _____

Home address: _____

Home phone: _____ Work phone: _____ Care Card Number: _____

Name of other health care providers: _____

How did you hear about this clinic: _____

Reason for referral or presenting problems:

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

MEDICATIONS

	Now	Past		Now	Past
Aspirin	_____	_____	Antibiotics	_____	_____
Tylenol	_____	_____	Allergies to meds	_____	_____
Ibuprofen	_____	_____	What meds?	_____	
Anti-histamine	_____	_____	Other:	_____	

MEDICAL HISTORY

Has your child had any of the following tests?	When	Where	Results
Electroencephalogram	_____	_____	_____
Psychological evaluation	_____	_____	_____
Hearing	_____	_____	_____
Speech/Language	_____	_____	_____

Injuries/Surgeries/Hospitalizations (please list): _____

IMMUNIZATIONS

Measles _____ Polio _____ MMR _____ Smallpox _____ Diphtheria _____ Mumps _____
DPT _____ Tetanus _____ Influenza _____ Other _____

Any adverse reactions? (Y/N) If so, what? _____

FAMILY HISTORY

Heart disease _____ Hypertension _____ Diabetes _____ Cancer _____ Tuberculosis _____
Mental illness _____ Allergies, asthma, hayfever _____

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages or complications? _____

Mother's age at birth? _____ Mother's health during pregnancy _____ Good _____ Poor _____

Nausea _____ Bleeding _____ Hypertension _____ Diabetes _____ Thyroid problems _____ Pre-eclampsia _____

Physical or emotional trauma _____ Cigarettes, alcohol, drug use _____

Other illnesses, if so, what? _____

Medications, if so, what? _____

BIRTH/POST-NATAL HISTORY

Term: Full _____ Premature _____ Late _____ Weight at birth _____

Length of labour _____ Complications? _____

Blue baby _____ Birth injuries _____ Birth defects _____ Jaundice _____

Colic Diarrhea _____ Rashes _____ Fever _____ Seizures _____

Child's sleep patterns (first year) _____

Food intolerances (if any) _____

Feeding: Breast-fed? _____ How long? _____ Formula? _____ Milk/soy _____

Age began solid foods _____ Which foods? _____

Age began: sitting _____ crawling _____ walking _____ talking _____

SYMPTOMS—mark if current (c) or past (p)

Hives _____ Burning of urine _____ Bloody urine _____ Frequent urination _____

Eczema _____ Cries easily _____ Nervous _____ Bleeding gums _____

Acne _____ Nose bleeds _____ Anemia _____ Heart murmur _____

Headaches _____ High fevers _____ Gas _____ Vomiting spells _____

Diarrhea _____ Stomach aches _____ Fatigue _____ Sleep problems _____

Cough _____ Chronic rash _____ Constipation _____ Sensitive to light _____

Wheezing _____ Hearing loss _____ No appetite _____ Body/breath odour _____

Hair loss _____ Easy bruising _____ Canker sores _____ Motion/Car sick _____

Dizzy spells _____ Sore throats _____ Nightmares _____ Unusual fears _____

Asthma _____ Ear infections _____ Measles _____ Chicken pox _____

Mumps _____ Scarlet fever _____ Rubella _____ Rheumatic fever _____

Allergies _____ To what? _____

Other _____

DIET

Please describe your child's typical daily diet:

Morning: _____

Noon: _____

Evenings: _____

Snacks: _____

Thank you! I look forward to helping you and your family!