PEDIATRIC INTAKE FORM

Child's name: ____

Date of birth:_______________ Sex: M F

Address: ____

Parent(s) names: ____

Parent(s) occupations: ____

Contact numbers: H (___)_____________ W (___) ____________

With whom does this child live? _______________ any siblings? _________

Is this child adopted? __________

Other contacts: name ____________________

phone ____________________

relationship ________________

What are your child's primary health concerns?

1. ____
2. ____
3. ____

How would you generally describe your child's health? EXCELLENT GOOD FAIR POOR

Please indicate any serious illnesses, conditions, surgeries, hospitalizations or injuries:

____ date ____________

____ date ____________

____ date ____________

Check any of the following illnesses that your child has had:

❑Rubella (German measles)	❑ Roseola	❑ Impetigo
❑Chicken Pox	❑ Scarlet fever	❑ Mononucleosis
❑Mumps	❑ Whooping cough	❑ Ear infections
❑Polio	❑ Strep throat	❑ High fevers

List any allergies your child has: ____

List any medications your child is currently taking: __________________________

____

List any supplements (vitamins), homeopathics, etc that your child currently takes:

____

How many times has your child been treated with antibiotics? ___________________

List all past medications: ____

Has your child been vaccinated? ______. If so, **all** scheduled vaccines? _______

Any reactions to vaccination? ____

Any screening tests (blood, allergy, hearing, vision, etc)? ______________________

____

Medical History:

Please indicate with a check mark for current conditions, M for conditions mother has had, F for father, and X for other family members.

	alcoholism		epilepsy		mental illness		scarlet fever
	allergies		frequent colds		migraines		skin disease
	arthritis		gonorrhea		multiple sclerosis		stroke
	asthma		hayfever		parasites		syphilis
	cancer		heart disease		pneumonia		thyroid problems
	colitis		hepatitis		prostatitis		tuberculosis
	depression		herpes		rheumatic fever		venereal warts/HPV
	diabetes		HIV		rape/sexual abuse		Other:
	drug addiction(s)		kidney disease		reproductive surgery		
	eczema		leukemia		rheumatoid arthritis		

Prenatal History:

Age of parents at conception: M _______ F _______

Health of mother at conception: excellent good fair poor

Was there any previous history of infertility or fertility treatments? ___________________

Was the pregnancy planned? ___________ Did the mother receive prenatal care? _______

Did the mother experience any of the following during pregnancy:

- ❑ bleeding
- ❑ diabetes
- ❑ high blood pressure
- ❑ thyroid prob's
- ❑ nausea
- ❑ vomiting
- ❑ physical or emotional trauma
- ❑ alcohol, smoking, drug use

List any supplements, prescription medications or over-the-counter drugs the mother took during pregnancy: ____

____

Birth History:

Was the birth to term? _________ Number of weeks premature/late _______________

What was the overall labour experience? ____

Length of labour: _______________ Complications: ___________________________________

Location of birth: Home Hospital Other

Delivery: Vaginal C-section Induced Forceps Anaesthesia used

Weight at birth: ______________

Check any of the following that were present at or shortly after birth:

- ❑ birth injuries
- ❑ birth defects
- ❑ jaundice
- ❑ rashes
- ❑ seizures
- ❑ infections
- ❑ respiratory distress
- ❑ other _________________________________

Breastfed? _________ How long? _________________
Formula fed? _________ What brands/types? ______________________________________
What foods were introduced?
before 6 months: ____
after 6 months: ____
Did your child experience colic? __________________________________
Any food allergies? ____
Any dietary restrictions (ethical vegetarian, religious, etc)? __________________________
____

Developmental History:

Overall health in first year of life: excellent good fair poor unknown
At what age did your child:
sit up ________ crawl ________ walk ________ talk ________ first teeth ________
What is your perception of your child's physical and emotional development?
____

Please describe your child's:

- temperament ____
- personality ____
- sleep pattern ____
- school performance ____
- social behaviour ____

Environmental History:

Is the child in: school home daycare other
Does your child exercise regularly?
____
What are your child's favourite activities?
____
How many hours of television does your child watch per week? ______________________
How many hours per week does your child use a computer/play video games? _________
How often does your child read/is read to? ________________

Is your child exposed to cigarette smoke? _____________
Is your child exposed to any toxins or hazards in the home? ________________________
Are there any pets in the home? ____
How is the home heated? ________________________

What is the emotional climate of the home? _______________________________________
Are there any ethical or cultural considerations I should be aware of?
____
Is there anything else you would like me to know that hasn't been covered?
____
____

PARENTAL CONSENT TO TREATMENT

Treatment at **Pura Vida Health Centre** is wellness-based, founded on individual treatment, financial accessibility, informed consent, and integrative complementary medicine, in an atmosphere that is supportive and healing to clients, practitioners and our environment.

Treatment at **Pura Vida Health Centre** may include the following modalities and diagnostic procedures:

- botanical medicine
- homeopathy
- clinical nutrition
- Traditional Chinese Medicine including acupuncture
- hydrotherapy
- bodywork
- lifestyle counseling
- physical examination
- urinalysis
- osteopathy
- massage therapy
- Bowen therapy

Not all of the above modalities and diagnostic services will necessarily be appropriate in your case at all times and may or may not be implemented by your therapist. All procedures and treatments will be fully explained to you and your child, including the expected cost of the procedures and treatments, expected length of treatment, any adverse effects of or alternative choices to a specific treatment, and consequences of not obtaining treatment, before your treatment plan is undertaken. Payment for all services and procedures is due at time rendered. All information exchanged between you, your child, and your therapist is confidential, and your privacy is assured.

I, ______________________________________ , ________________________ of

PARENT'S OR GUARDIAN'S NAME RELATIONSHIP TO CHILD

____________________________________ consent to treatment by my registered therapist

CHILD'S NAME

____, and have been fully informed of the nature of all therapeutic procedures, services, diagnostic tests.

____ _____________________

SIGNATURE PARENT OR GUAURDIAN DATE