

**THEODORA C. LO, B.Sc., N.D.**

**CENTRE FOR PREVENTIVE MEDICINE**

**202, 4411-16<sup>TH</sup> AVENUE, N.W.**

**CALGARY, ALBERTA**

**(403) 286-7311**

**PEDIATRIC INTAKE FORM (6-12 years)**

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_ Date of Birth \_\_\_\_\_ Gender: Female \_\_\_\_\_ Male \_\_\_\_\_

Mother's name \_\_\_\_\_ Father's name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone # (home) \_\_\_\_\_

Alberta Health Care Number \_\_\_\_\_

How did you hear about this clinic \_\_\_\_\_

**HEALTH HISTORY QUESTIONNAIRE**

What are your child's most important health problems? List as many as you can in order of importance.

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

Does your child have a contagious disease at this time?      Y N

If yes, what? \_\_\_\_\_

**Previous Illnesses**

Rheumatic fever	Y N	German measles	Y N
Chicken pox	Y N	Measles	Y N
Tonsillitis	Y N	approx. number	_____
Ear infections	Y N	approx. number	_____
Other	Y N	list	_____

**PLEASE FILL OUT BOTH SIDES OF EACH PAGE**

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

Electroencephalogram (EEG) \_\_\_\_\_  
Psychological evaluation \_\_\_\_\_  
Hearing tests \_\_\_\_\_  
Speech/Language tests \_\_\_\_\_

### Hospitalizations/ Surgeries/ Injuries

What hospitalizations, surgeries or injuries has your child had?

\_\_\_\_\_  
\_\_\_\_\_

### Immunizations

Polio	Y N	Pertussis	Y N
Tetanus shot	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Influenza	Y N
Any adverse reactions?	Y N	If yes, what ?	_____

### Allergies

Is your child hypersensitive or allergic to:

Any drugs? \_\_\_\_\_

Any foods? \_\_\_\_\_

Any environmental? \_\_\_\_\_

Breast fed? \_\_\_\_\_ How long? \_\_\_\_\_ Formula? \_\_\_\_\_ Milk / Soy \_\_\_\_\_

### Typical Food Intake

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

To Drink: \_\_\_\_\_

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

1) \_\_\_\_\_ 4) \_\_\_\_\_

2) \_\_\_\_\_ 5) \_\_\_\_\_

3) \_\_\_\_\_ 6) \_\_\_\_\_

### REVIEW OF SYSTEMS

Y = a condition now

N = never had

**MENTAL/ EMOTIONAL**

Mood Swings	Y	N	Anxiety/nervousness	Y	N
Irritability	Y	N	Cries easily	Y	N
Hyperactivity	Y	N	Unusual fears	Y	N
Introvert/extrovert	Y	N	Sleep problems	Y	N
Motion/car sickness	Y	N	Nightmares	Y	N

**ENDOCRINE**

Heat/cold intolerance	Y	N	Fatigue	Y	N
Excessive thirst	Y	N	Excessive hunger	Y	N
Low blood sugar	Y	N	High blood sugar	Y	N

**SKIN**

Rashes	Y	N	Eczema, Hives	Y	N
Acne, Boils	Y	N	Itching	Y	N

**HEAD**

Headaches	Y	N	Head Injury	Y	N
Dizzy spells	Y	N	High fevers	Y	N

**EYES**

Glasses or contacts	Y	N	Tearing or dryness	Y	N
Eye pain/strain	Y	N			

**EARS**

Earaches	Y	N	Impaired hearing	Y	N
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**NOSE AND SINUSES**

Frequent colds	Y	N	Nose Bleeds	Y	N
Stuffiness	Y	N	Hayfever	Y	N
Sinus problems	Y	N	Loss of smell	Y	N

**MOUTH AND THROAT**

Frequent sore throat	Y	N	Canker sores	Y	N
Breath odor	Y	N			

**RESPIRATORY**

Cough	Y	N	Wheezing	Y	N
Asthma	Y	N	Bronchitis	Y	N

**CARDIOVASCULAR**

Heart disease	Y	N	Murmurs	Y	N
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**REVIEW OF SYSTEMS**

**Y** = a condition now                      **N** = never had

**URINARY**

Frequent urination	Y	N	Bed wetting	Y	N
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**GASTROINTESTINAL**

Belching/passing gas	Y	N	Stomach aches	Y	N
Constipation	Y	N	Diarrhea	Y	N
Bowel Movements	How often _____				

**MUSCULOSKELETAL**

Joint pain/stiffness	Y	N	Muscle spasms/cramps	Y	N
Broken bones	Y	N			

**BLOOD/PERIPHERAL VASCULAR**

Anemia	Y	N	Easy bleeding/bruising	Y	N
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Is there any information about your child's health that you would like to add?

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Welcome! I am glad to be of service for you and your child!