

**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 (Birth- 5 years)**

Patient's name \_\_\_\_\_ Date of first visit \_\_\_\_\_

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

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

Address \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_

Telephone (home) (\_\_\_\_) \_\_\_\_\_ Parents work # (\_\_\_\_) \_\_\_\_\_

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

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

Name of Dr.'s Office/Hospital/Clinic where your child's health records are kept \_\_\_\_\_

Reason for referral or presenting problems \_\_\_\_\_

<b>MEDICATIONS</b>	Now	Past		Now	Past
Aspirin	_____	_____	Antibiotics	_____	_____
Tylenol	_____	_____	Anti-histamine	_____	_____
Decongestant	_____	_____	Other	_____	_____
Ibuprofen	_____	_____	Allergies to medicines	_____	

**MEDICAL HISTORY**

_____ Chicken pox	_____ Scarlet fever	_____ Tonsillitis, approx. number
_____ Measles	_____ Pneumonia	_____ Ear infections, approx. number
_____ Mumps	_____ Frequent colds	_____ other (please list) _____
_____ Rubella	_____ Rheumatic fever	_____

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

Psychological evaluation \_\_\_\_\_

Hearing \_\_\_\_\_

Speech/Language \_\_\_\_\_

Injuries/Surgeries/Hospitalizations (please list) \_\_\_\_\_

**PLEASE COMPLETE BOTH SIDES**

**IMMUNIZATIONS**

Measles \_\_\_ Polio \_\_\_ MMR \_\_\_ Smallpox \_\_\_ Diphtheria \_\_\_  
Mumps \_\_\_ DPT \_\_\_ Tetanus \_\_\_ Influenza \_\_\_  
Others (list) \_\_\_\_\_  
Any adverse reactions? Y N What ? \_\_\_\_\_

**FAMILY HISTORY**

\_\_\_ Heart disease                      \_\_\_ Diabetes                      \_\_\_ Birth defects  
\_\_\_ Hypertension                      \_\_\_ Arthritis                      \_\_\_ Tuberculosis  
\_\_\_ Cancer                              \_\_\_ Allergies                      \_\_\_ Mental illness

**PRENATAL HISTORY**

Previous pregnancies by natural mother, miscarriages, or complications? \_\_\_\_\_  
Mother's age at child's birth? \_\_\_\_\_  
Mother's health during pregnancy?  
    \_\_\_ Bleeding                      \_\_\_ Physical or emotional trauma  
    \_\_\_ Nausea                        \_\_\_ Cigarettes, alcohol, drug consumption  
    \_\_\_ Illnesses                      \_\_\_ Medications  
    \_\_\_ Hypertension                \_\_\_ Thyroid problems  
    \_\_\_ Diabetes

**BIRTH HISTORY**

Term: Full \_\_\_ Premature \_\_\_ Late \_\_\_ Weight at birth \_\_\_\_\_  
Length of labor \_\_\_\_\_ Complications? \_\_\_\_\_  
Did your child have any of the following problems shortly after birth?  
\_\_\_ Birth defects                      \_\_\_ Birth injuries                      \_\_\_ Blue baby  
\_\_\_ Cerebral palsy                      \_\_\_ Seizures                              \_\_\_ Jaundice  
\_\_\_ Colic                                \_\_\_ Fever                                \_\_\_ Rashes  
Other (explain) \_\_\_\_\_  
Child's sleep patterns (first year) \_\_\_\_\_  
Food intolerances (if any) \_\_\_\_\_  
Feeding: Breast fed? \_\_\_ How long? \_\_\_ Formula? milk / soy \_\_\_  
Age began solids \_\_\_\_\_ Which foods? \_\_\_\_\_  
Age began: Sitting \_\_\_ Crawling \_\_\_ Walking \_\_\_ Talking \_\_\_\_\_

**SYMPTOMS** (mark **Y** if current, **P** for past symptoms)

\_\_\_ Hives                                \_\_\_ Burning of urine                      \_\_\_ Bloody urine  
\_\_\_ Eczema                              \_\_\_ Frequent urination                      \_\_\_ Cries easily  
\_\_\_ Bleeding gums                      \_\_\_ Heart murmur                              \_\_\_ Nervous  
\_\_\_ Nose bleeds                        \_\_\_ Vomiting spells                              \_\_\_ Sleep problems

**SYMPTOMS - continued** (mark **Y** if current, **P** for past symptoms)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Acne           | <input type="checkbox"/> Anemia            | <input type="checkbox"/> Night sweats         |
| <input type="checkbox"/> High fevers    | <input type="checkbox"/> Stomach aches     | <input type="checkbox"/> Sensitive to light   |
| <input type="checkbox"/> Chronic rash   | <input type="checkbox"/> Jaundice          | <input type="checkbox"/> Body/breath odor     |
| <input type="checkbox"/> Hearing loss   | <input type="checkbox"/> Easy bruising     | <input type="checkbox"/> Motion/ car sickness |
| <input type="checkbox"/> Diarrhea       | <input type="checkbox"/> Flat feet         | <input type="checkbox"/> No appetite          |
| <input type="checkbox"/> Sore throats   | <input type="checkbox"/> Constipation      | <input type="checkbox"/> Nightmares           |
| <input type="checkbox"/> Headaches      | <input type="checkbox"/> Gas               | <input type="checkbox"/> Canker sores         |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Unusual fears        |
| <input type="checkbox"/> Wheezing       | <input type="checkbox"/> Joint pains       | <input type="checkbox"/> Excessive fatigue    |
| <input type="checkbox"/> Cough          | <input type="checkbox"/> Dizzy spells      | <input type="checkbox"/> Hair loss            |

**DIET**

Please describe your child's typical daily diet:

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

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

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

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

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

**Thank you!! I look forward to helping your child in any way I can.**