Jay Grossman

Chiropractor | Naturopath
MSc, DC, ND, DIBAK

42Wellness
1560 Yonge Street, Suite 210
Toronto, ON M4T 2S9
Ph: (416) 887-1400

PEDIATRIC INTAKE FORM

Child's full name_____ Age_____ Date of Birth_____ Sex? (M/F)_____
Address_____City_____Postal Code_____
Phone_____ Email address_____
Full name of mother/guardian _____ Phone (H)_____
Occupation _____ Phone(W)_____ Fax_____
Full name of father/guardian _____ Phone (H)_____
Occupation _____ Phone(W)_____ Fax_____
Marital status of parents_____
Please indicate any special living arrangements your child may have_____
Emergency Contact/Number_____ Emergency Contact/Number_____
Names of siblings & ages _____
Family Physician_____ Other Health Care Practitioners_____
How did you hear about Dr. Smith?_____

HEALTH CONCERNS (please list in order of importance):

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

MEDICAL HISTORY

Date of last physical exam_____ Height_____ Weight_____ Blood Type_____
Hours of sleep per night?_____ Bedtime?_____ Sleeping problems?_____
Current Medications and Dosages (including over the counter)_____
_____
Past Medications_____
How many times has your child been treated with antibiotics?_____
current vitamins, minerals, supplements or herbal products and dosages_____
_____
Does your child have allergies?_____ To what?_____
Does your child experience frequent colds and/or flus (now or in the past)?_____
Has your child had X-rays?_____ If so, when and why?_____
Has your child had labwork or other medical testing in the last year? _____ List explain_____
_____
Please circle which of the following diseases your child has had: *Measles German Measles Chicken Pox Mumps Whooping Cough Strep throat Impetigo Scarlet Fever Mononucleosis Other*_____
Please circle which vaccinations your child has had: *Tetanus Pertussis Diptheria Polio Measles Mumps Rubella Varicella Hepatitis B Influenza H1N1 Other*_____
Please note any reactions to these vaccinations (fever, etc)_____

Please list major accidents, hospitalizations, surgeries, diseases, traumatic events & age at the time:

Event	Age	Event	Age
1.		2.	
3.		4.	
5.		6.	

PRENATAL/PREGNANCY HISTORY

BIOLOGICAL MOTHER (if possible)

Age at conception_____ Health at the time (please circle) *Excellent* *Good* *Fair* *Poor*

Medications taken at conception and during the pregnancy (prescription and over-the-counter)_____

_____

vitamins/supplements/herbs taken at conception and during pregnancy_____

_____

Was this a particularly emotional time for the mother? _____

Please circle which of the following the mother experienced during the pregnancy: *Nausea* *Vomiting* *Bleeding* *Diabetes* *Thyroid Problems* *High Blood Pressure* *Pre-Eclampsia* *Eclampsia* *Physical Trauma* *Emotional Trauma* Other_____

Were cigarettes, alcohol or recreational drugs used?_____ Which/How often?_____

BIOLOGICAL FATHER (if possible):

Age at conception_____ Health at the time (please circle) *Excellent* *Good* *Fair* *Poor*

Medications/supplements taken by the father at the time of conception_____

Was this a particularly emotional time for the father? (Explain) _____

LABOUR HISTORY

Place of Birth_____ Vaginal delivery or C-Section?_____ Length of labour_____

Was the pregnancy (please circle): *Full term* *Premature* *Past term* Were there any complications?_____

Were any medications/interventions used? (ie pitosin, forceps, etc)_____

NEONATAL HISTORY

Weight_____ Length_____ APGAR scores_____ Any concerns at birth?_____

Was this child breast-fed?_____ Until what age?_____ If no, what formula was given?_____

Were there any feeding problems?_____ Were solid foods given before 6 months of age?_____

Please indicate the *approximate* age at which the following were introduced: *Formula & Type* _____

*Fruit*_____ *Vegetables*_____ *Soy*_____ *Milk*_____ *Eggs*_____ *Wheat*_____ *Meat*_____

Please explain any adverse reactions_____

NUTRITIONAL HABITS

Please describe a typical day's diet for your child:

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Beverages_____

Please list your child's favorite foods_____

FAMILY MEDICAL HISTORY: (check boxes if any family members have had any conditions below)

	Mother	Father	Sister/Brother	Grandparents	Other Relative
Autoimmune Disease (Lupus, etc)					
Alcoholism					
Allergies/Asthma					
Anemia					
Arthritis					
Cancer					
Depression/Mood swings					
Diabetes					
Eczema/Psoriasis					
Epilepsy					
Heart Disease					
Hyperactivity					
Kidney Disease					
Learning Disability					
Psychological Disorder					
Other					

Is there anything else that you feel I should know about your child?