

Pediatric Intake Form

Name: _____

Date: _____

Date of Birth: ____/____/____ (DD/MM/YYYY)

Male Female

Address: _____

Height: _____

City: _____ Postal Code: _____

Weight: _____

Home Phone: _____

Parent's Work Phone: _____

Name of Parents / Guardian: _____

Emergency Contact

Name: _____

Phone: _____

Relationship to child: _____

Family Doctor

Name: _____

Phone: _____

Address: _____

Date of last appt./physical: _____

Other Health Care Professionals

(Medical specialist, naturopath, homeopath, physiotherapist, massage therapist, etc.)

Name: _____

Phone: _____

Professional Designation: _____

Address: _____

Date of last appt./physical: _____

Name: _____

Phone: _____

Professional Designation: _____

Address: _____

Date of last appt./physical: _____

Is your child currently taking any medication? Yes No If yes, please specify: _____

Has your child taken any medications for an extended period of time in the past? Yes No

If yes, please specify: _____

Is your child taking any herbal or vitamin supplementation? Yes No

If yes, please specify: _____

Has your child received vaccinations? Yes No

Does your child exercise? Yes No

What complaint / concern brings you in? _____

How long has your child been experiencing this? _____

Is it getting better, worse or staying the same? _____

Have you seen other health professionals regarding this complaint? And if so, whom?

What treatment did they use? _____

Has your child taken medication for this complaint? Yes No

Has your child ever experienced this complaint before? Yes No If yes, when? _____

Did they receive any treatment at the time? Yes No

Has your child had x-rays in relation to the current complaint? Yes No

Child Health History

Please CHECK anything which is currently causing your child problems / concern.

Please CIRCLE anything which has been a problem / concern for your child in the past.

Ear infections

Scoliosis

Seizures

Chronic colds

Headaches

Asthma

Upper respiratory infections

Allergies

Food sensitivities

Digestive problems

Diarrhea

Constipation

Sinus troubles

Recurring fevers

Bed wetting

Colic

Growing pains

Eczema / skin irritations

Neck pains

Back pains

ADD / ADHD

Has your child experienced any of the following illnesses:

Chicken pox

Whooping cough

Mumps

Rubella

Rubeola

Developmental History

Has your child ever fallen from any high places? Yes No

Is / was your child ever involved in any contact sports? Yes No

Has your child ever been involved in a motor vehicle accident? Yes No

Developmental History con't....

Has your child ever been seen on an emergency basis?

Yes No

Has your child ever broken any bones?

Yes No

Any previous hospitalizations?

Yes No

Any previous surgeries?

Yes No

Prenatal History

Ultra-sounds during pregnancy: Yes No

Medications during pregnancy: Yes No If yes, please specify: _____

Medications during labour / delivery: Yes No If yes, please specify: _____

Were you induced? Yes No

Was your child at anytime during your pregnancy in an intra-uterine constricting position, such as:

Breech Transverse Face / brow presentation

Was your delivery vaginal or C-section? _____

If it was a C-section, was it planned or emergency? _____

Were any of the following used during delivery:

Forceps Vacuum extraction other, please specify _____

Were there any complications during delivery? Yes No If yes, please specify: _____

Was your child breastfed? Yes No If yes, for how long: _____

What do you hope to achieve for your child by coming to Village Wellness?

Our primary goal is to work towards the resolution of your current condition as quickly as possible through excellent health care and patient education while helping to prevent you from experiencing this condition again.

Do you have any specific concerns about the therapies that we provide?

We will always give a thorough explanation of what we've found in our history and physical exam; explain the condition we believe you to be suffering from as well as the treatment options available to you, the expected outcome and any risks involved. Always feel free to ask questions at any stage of your treatment, Good communication is an important part of the treatment and prevention process at Village Wellness.

I hereby authorize the health care professionals at Village Wellness, with my prior knowledge, to release to or obtain any health information from my other health care providers as may be required for the management of my case.

I have read and understood the Village Wellness at Appaloosa fee schedule and cancellation policy. I am aware that if insurance claims are being submitted on my behalf that I am responsible for any outstanding balance not covered by my insurance policy.

Name of Child: _____ Date: _____

Parent / Guardian Signature: _____