Selkirk Clinic

Pediatric Intake Form (ages 6-12)

Patient's Name: _____ Date: _____

Parent/Guardian's Name: _____

Date of Birth: _____ Gender: Female / Male

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone (home): _____ (Parent's cell):_____

Parent's email address: _____

Would you like to receive Selkirk's E-Newsletter (health tips, recipes, clinic updates)? Yes / No

How did you hear about our clinic? _____

What are your child's most important health problems? List in order of importance:

1._____

2._____

3. _____

4. _____

Does your child have a contagious disease at this time? Y/N If yes, what? _____

MEDICATIONS / SUPPLEMENTS

Please list any *current and past* medications or supplements (include dose):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Approximately how many times has your child been treated with antibiotics? _____

MEDICAL HISTORY

- Frequent colds: Y/N
- Chicken pox: Y/N
- Measles: Y/N
- Rheumatic fever: Y/N
- Mumps: Y/N
- Rubella: Y/N
- Scarlet fever: Y/N
- Pneumonia: Y/N
- Tonsillitis, # of times: _____
- Strep throat, # of times: _____
- Ear infections, # of times: _____
- Other: _____

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Has your child ever had any of the following? (Please elaborate on when, where, and the results)

Electroencephalograms (EEG), psychological evaluations, hearing tests, or speech/language tests?

_____

Please list if your child has had any: serious medical conditions, injuries, surgeries, or hospitalizations: _____

_____

May we contact your family medical doctor to get a copy of past lab test? Y/N

Doctor's name: _____ Telephone #: _____

IMMUNIZATIONS

- HBV (Hepatitis B): Y/N
- Hib (Hemophilus influenza type B): Y/N
- DTaP (Diphtheria, Tetanus, Pertussis): Y/N
- Varicella (chicken pox): Y/N
- MMR (Measles, Mumps, Rubella): Y/N
- PCV (Pneumococcal Bacteria): Y/N
- IPV (Polio): Y/N
- HAV (Hepatitis A): Y/N
- Td (Tetanus, Diphtheria): Y/N
- MCV4 (Meningitis): Y/N
- Influenza: Y/N

Any reactions to Immunizations? _____

FAMILY HISTORY

____ Heart disease	____ Diabetes	____ Birth defects
____ Hypertension	____ Arthritis	____ Tuberculosis
____ Cancer	____ Allergies	____ Asthma
____ Mental illness	____ Osteoporosis	____ Other: _____

ALLERGIES

Do you suspect your child is hypersensitive or allergic to any medications, food, or environmental allergens (dust, dander, pollens, etc.)? _____

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HABITS

Main interests and hobbies: _____

Day Care ☐ School ☐ Home school ☐ Grade: _____

Does your child read? Y/N How many hours per day? _____

Does your child play sports? Y/N How many hours per day? _____

Does your child play video games? Y/N How many hours per day? _____

Does your child watch TV? Y/N How many hours per day? _____

How many bowel movements does your child have per day? _____

DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

SOCIAL HISTORY

Does anyone in the home smoke? Y/N Any animals in the home? _____

When did the child last travel out of country, and where? _____

Whom does the child live with? _____ Are the parents divorced/separated? Y/N

Please describe the emotional climate of the home: _____

Do you know of any toxins or other hazards the child is regularly exposed to (ie. household cleaners, mold, hobbies with paint, glues, etc.): _____

By signing below I give my written consent for the evaluation and treatment of my child. I intend this as a consent to cover the entire course of treatments for my child's present condition and any future conditions for which we seek treatment.

_____ _____

Printed Name of Guardian *Signature of Guardian*

REVIEW OF SYSTEMS

Please circle any symptoms below that your child experiences now or that was a significant problem in the past.

MENTAL/EMOTIONAL
- Mood Swings
- Irritability
- Hyperactivity
- Introvert/extrovert
- Motion/car sickness
- Anxiety/nervousness
- Cries easily
- Unusual fears
- Sleep problems
- Nightmares

ENDOCRINE
- Heat/cold intolerance
- Fatigue
- Excessive thirst
- Excessive hunger
- Low blood sugar
- High blood sugar

SKIN
- Rashes
- Eczema, Hives
- Acne, Boils
- Itching

HEAD
- Headaches
- Head Injury
- Dizzy spells
- High fevers

EYES
- Glasses or contacts
- Tearing or dryness
- Eye pain/strain

EARS
- Earaches
- Impaired hearing

NOSE AND SINUSES
- Frequent colds
- Nose Bleeds
- Stuffiness
- Hayfever
- Sinus problems
- Loss of smell

MOUTH AND THROAT
- Frequent sore throat
- Canker sores
- Breath odor

RESPIRATORY
- Cough
- Wheezing
- Asthma
- Bronchitis

CARDIOVASCULAR
- Heart disease
- Murmurs

URINARY
- Frequent urination
- Bed wetting

GASTROINTESTINAL
- Belching/passing gas
- Stomach aches
- Constipation
- Diarrhea

MUSCULOSKELETAL
- Joint pain/stiffness
- Muscle spasms
- Muscle cramps
- Broken bones

BLOOD/PERIPHERAL VASCULAR
- Anemia
- Easy bruising
- Easy bleeding

Thank you and we look forward to guiding you in your child's health care!