NEW PATIENT INTAKE FORM – PEDIATRIC

CHILD'S PERSONAL INFORMATION

Full Name: AHC#:

Phone Number: Date of Birth: / /

Home Address:

City: Province: Postal Code:

Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Prefer Not to Say

Parent/Guardian Name: Relationship: Phone:

Parent/Guardian Name: Relationship: Phone:

BIRTH HISTORY

Type of delivery: ☐ Vaginal ☐ Assisted ☐ C-Section

Interventions: ☐ Forceps ☐ Vacuum ☐ Induction ☐ Epidural

PREGNANCY HISTORY

Natural conception: ☐ Yes ☐ No

If natural, time to conceive: _____

Mother's activity during pregnancy: ☐ Low ☐ Moderate ☐ Active

Stress levels during pregnancy: ☐ Low ☐ Moderate ☐ High

Nutrition during pregnancy: ☐ Balanced ☐ Moderate ☐ Poor

Morning sickness: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Medications during pregnancy: _____

REASON FOR SEEKING CARE

What brings your child into our office?

_____

_____

_____

_____

How long has this been present? ☐ Recent ☐ Weeks ☐ Months ☐ Years

Have they experienced this before? ☐ Yes ☐ No

DEVELOPMENT & HEALTH

Any concerns with development (feeding, sleep, movement, milestones):

Previous injuries or falls:

CURRENT LIFESTYLE

Sleep: ☐ Good ☐ Interuppted ☐ Poor

Energy: ☐ High ☐ Moderate ☐ Low

Activity level: ☐ Low ☐ Moderate ☐ High

NUTRITION

☐ Breastfed ☐ Formula ☐ Both

If eating solids:

Carbohydrates: ☐ Low ☐ Moderate ☐ High

Protein: ☐ Low ☐ Moderate ☐ High

Fats: ☐ Low ☐ Moderate ☐ High

Sugars: ☐ Low ☐ Moderate ☐ High

Water Intake: ☐ Low ☐ Moderate ☐ High

Gluten intake: ☐ Low ☐ Moderate ☐ High

Dairy intake: ☐ Low ☐ Moderate ☐ High

Water Intake: ☐ Low ☐ Moderate ☐ High

High processed foods: ☐ Low ☐ Moderate ☐ High

GOALS FOR CARE

Is there anything else you would like us to know about child's health, or goals for care?