Marsden Centre
for Excellence In Integrative Medicine

PEDIATRIC INTAKE FORM

Date: _____
Who is filling out this form (name and relation): _____
Referred by: _____

Patient Information					
Name	Date of Birth	Age	Gender	Height	Weight

Parents/Guardians
Names: _____
Address: _____
_____
Email: _____
Phone: home_____ work_____ cell_____

Family General Practitioner or Pediatrician
Name: _____
Phone: _____

Other Health Care Provider(s)
Name: _____
Type of Practitioner: _____
Phone: _____

Reason(s) for Visit/Chief Concerns (in order of importance)	
Chief concern	**Any prior treatment(s), please describe**
1.	
2.	
3.	

Current medications and supplements: _____
_____
Past Medications: _____
_____
Any allergies? Please describe: _____
_____

Please check (✔) any of the following that applied to the pregnancy

Prenatal and Birth Information					
Diabetes		Nausea		Alcohol/drug use	
Bleeding		Vomiting		High blood pressure	
Thyroid problems		Infections		Other	

Mother's age of this pregnancy: _____
# of previous pregnancies: _____
# of previous miscarriages: _____

Marsden Centre
for Excellence In Integrative Medicine

Prenatal and Birth Information Continued

During the pregnancy:

1. Was there any physical or emotional trauma? (accidents, abuse, death in the family)
   _____

2. What medications and supplements were taken (if any)?
   _____
   _____
   _____

3. Any exposure to diseases? Y___ N ___ What disease(s)? _____

4. Any traveling? Y ___ N ___ Where? _____

5. Occupation:_____ Where? _____

6. Where was the birth? Home/Hospital (name of hospital: _____)

Please check (✔) the following interventions, if any were applied:

Induction		Episiotomy	
Pitocin		Forceps	
Pain medication		Vacuum extraction	
C-section		Other	
Epidural			

How long was the labour (hours)? _____ Full term or pre-term (indicate in weeks)_____

Infant weight: _____ length: _____ head circumference: _____

APGAR score (if known): birth: _____ 1 minute: _____ 5 minutes: _____

Please check (✔) any of the following that apply:

Neonatal History					
Congenital defects		Infections		Respiratory distress	
Anemia		Poor feeding		Colic	
Jaundice		Rashes		Other (please explain)	

Was the infant breastfed? (Y / N) How long? _____

Was the infant formula fed? (Y / N) Which formula was/is used? _____

When was solid food introduced? _____ Which foods ? _____

Are there any foods that are excluded from the child's diet? (please explain)
_____
_____

Marsden Centre
for Excellence In Integrative Medicine

Please check (✔) any of the following vaccinations that have been given:

Other Medical History					
Diptheria		Measles		Chicken pox	
Pertussis		Mumps		Flu shot	
Tetanus		Rubella		Other	
Polio		Hepatitis			

Any adverse reactions to any of the above? (please describe)

_____

_____

_____

Any previous hospitalizations or surgeries? (please describe)

_____

_____

Family Health History		
Family Member	**Age**	**List any Illnesses**
Mother		
Father		
Siblings		
Maternal grandmother		
Maternal grandfather		
Paternal grandmother		
Paternal grandfather		

Other

School/Day Care performance (general):_____

Interests:_____

Has the child been diagnosed as having any learning disabilities? (Y / N)

If yes, what disability? _____

Favourite activity: _____

Exercise (how long, how often): _____

_____

Any family member smokes? (Y / N)

Any pets in the home? _____

Sleep (Please Describe): _____

_____

_____