



487 Davie Street, Vancouver, BC V6B2G2 Phone (604) 697-0397 Fax (604) 697-0883

PEDIATRIC INTAKE FORM (Birth to 5 years)

Patient's name: _____ Date of first visit: _____

Age: _____ Date of Birth (month/day/year): ____/____/____ Gender: female male

Mother's name: _____ Father's name: _____

Address: _____ City: _____ Province: ____ Postal Code: _____

Phone number (home): (____) _____ Parent's work phone number (____) _____

Parent's e-mail address: _____

How did you hear about Sage Clinic? _____

Child's GP or Pediatrician: _____

Current health concerns: _____

MEDICAL HISTORY

____ Chicken pox ____ Scarlet fever ____ Roseola ____ Mononucleosis
____ Measles ____ Pneumonia ____ Strep throat ____ Impetigo
____ Mumps ____ Whooping Cough ____ Ear Infections
____ Rubella ____ Rheumatic fever ____ other (please list) _____

What screening tests has your child had? (blood, hearing, vision, etc) _____

Serious Illnesses/Injuries/Surgeries/Hospitalizations (please list): _____

Please list all current medications (prescription, over the counter, vitamins, herbs, homeopathics, etc.) _____

Please list any past prescription medications: _____

IMMUNIZATIONS

____ MMR ____ Polio ____ MMR ____ Smallpox ____ H. Influenza B
____ DPT ____ Influenza ____ Hepatitis B ____ Hepatitis A ____ Other: _____

Any adverse reactions to vaccines: yes no If yes, please describe: _____

FAMILY HISTORY

____ Heart disease ____ Diabetes ____ Birth abnormality ____ Celiac disease Other: _____
____ Hypertension ____ Arthritis ____ Tuberculosis ____ Eczema Other: _____
____ Cancer ____ Allergies ____ Mental illness ____ Asthma Other: _____

BIRTH MOTHER'S PRENATAL HISTORY

Mother's age at child's birth? _____

Mother's health during pregnancy? _____

Were any of the following experienced during pregnancy?

____ Bleeding ____ Physical or emotional trauma ____ High blood pressure
____ Nausea/Vomiting ____ Cigarettes, alcohol, drug consumption ____ Thyroid problems
____ Illnesses ____ Medications ____ Gestational diabetes

CHILD'S BIRTH HISTORY

Term: Full Premature _____ weeks Late _____ weeks Weight at birth _____

Length of labor _____ Any complications? _____

Birth: vaginal C-section Induced Forceps Anesthesia used

Did your child have any of the following problems shortly after birth?

_____ Birth abnormality _____ Birth injuries _____ Blue baby
_____ Cerebral palsy _____ Seizures _____ Jaundice
_____ Colic _____ Fever _____ Rashes

Other (explain) _____

Feeding: Breastfed? yes no How long? _____ Formula? yes no If Yes: cow's milk soy other

Child's sleep patterns _____

How would you describe your child's temperament? _____

Food or environmental allergies (if known) _____

Any dietary restrictions (religious, vegetarian, vegan, etc.)? _____

Age began solids _____ Which foods? _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS (mark **Y** if current, **P** significant past symptom)

_____ Hives _____ Burning of urine _____ Bloody urine
_____ Eczema _____ Frequent urination _____ Cries easily
_____ Bleeding gums _____ Heart murmur _____ Nervous
_____ Nose bleeds _____ Vomiting spells _____ Sleep problems
_____ Acne _____ Anemia _____ Night sweats
_____ High fevers _____ Stomach aches _____ Sensitive to light
_____ Chronic rash _____ Jaundice _____ Body/breath odor
_____ Hearing loss _____ Easy bruising _____ Motion/car sickness
_____ Diarrhea _____ Flat feet _____ No appetite
_____ Sore throats _____ Constipation _____ Nightmares
_____ Headaches _____ Gas _____ Canker sores
_____ Frequent colds _____ Bleeding tendency _____ Unusual fears
_____ Wheezing _____ Joint pains _____ Excessive fatigue
_____ Cough _____ Dizzy spells _____ Hair loss

Other: _____

What expectations do you have from this visit to our clinic?

What long-term expectations do you have for working with our clinic?

CONSENT AND CANCELLATION POLICY

I hereby consent to receive treatment by the practitioners of Sage Clinic. I understand that I am responsible for paying the full cost of treatment if I do not give 24 hours notice of change or cancellation.

EMAIL CORRESPONDENCE (we will not sell, rent, or share your email address)

Yes No - I would like to receive Sage Clinic's free monthly email newsletter, which contains information about clinic events, health conditions, current health news, and inspiring health quotations.

Yes No - Sage Clinic may correspond with me at the above email address.

Signature: _____ Today's date: _____
(Parent or Guardian)

Thank you. We look forward to helping your child in any way we can.