ALBERTA HEALTH INSTITUTE
101, 1422 KENSINGTON ROAD N.W., ALBERTA, T2N 3P9
PH: 403 521-5234

PEDIATRIC INTAKE FORM-16 yrs and under

PATIENT INFORMATION

Name:_____ Gender:_____
Date of Birth: _____ Current Height: _____ Weight: _____
Name of Parent/Guardian(s): _____
Address: _____
_____
Phone (Home) _____
(Work) _____
Emergency Contact (name, relation, address): _____
_____
Medical doctor: _____ M.D. Tel: _____
How did you hear about our centre? _____

HEALTH INFORMATION

Chief Concerns

1. _____
2. _____
3. _____

When was your child's last physical exam? _____

Medications **Supplements**

_____ _____
_____ _____
_____ _____

Medical history

Prenatal:

Age of parents at conception: Mother _____ Father _____
Occupation: Father _____ Maternity leave taken Y/ N
Mother _____ Maternity leave taken Y/ N
Worked how long into pregnancy? _____
Adopted, natural or assisted conception? _____
Testing done and when: _____
Breakfast _____
Lunch _____
Supper _____
Complications of pregnancy (i.e. toxemia, diabetes, bed rest, nausea, vomiting,medication, supplements)
_____
_____
Significant events or trauma during pregnancy, physical or emotional: _____
_____
Amount of exposure of the following during pregnancy:
Cigarette smoke _____ Alcohol _____
Environmental (i.e. cleaning products, cat litter, well water, new paint):
_____

Neonatal (labour and delivery):
Gestation (indicate if premature or over-due): _____
Type of care (ex. obstetric, midwife) and name of practitioner(s):
_____
Type of birth (vaginal, C-section) _____
Complications (breech, vacuum or forceps assisted) _____
History of miscarriage, stillbirth, multiple births: _____
Any genetic defects _____
Duration of labour _____ Medication, antibiotics (i.e. for Strep B), supplements given:
_____
_____
APGAR score (score, note any low scoring sections) _____
Birth weight: _____ Height: _____ Normal weight gain Y N
Neo-natal difficulties (jaundice, respiratory, failure to thrive, blood sugar complications, illness)
_____

Feeding:
Breast fed? If so, how long? _____
Substituted? If so, since when? _____ Reason(s) _____
Reactions _____
Weaning:
Age: _____ Success: _____
Food Introduction:
When: _____ What: _____
Any adverse reactions: _____
Cravings or aversions: _____
Current Diet:
Breakfast: _____
Lunch: _____
Supper: _____
Snacks: _____
Describe eating environment (i.e. location, timing with rest of family, picky):
_____

Other medical history:
Past illnesses _____
_____
Past hospitalizations, surgery (circumcision)_____
_____
Trauma/ accidents (mental, physical) _____
_____
Vaccinations (please include dates):
_____
_____
Major Developmental Milestones (please include approximate age at time):
First Roll (from front to back, or back to front) _____
First Unassisted Sitting Position _____
First Crawl _____
First Walk _____
First Words _____
First Teeth _____

Family history

Please note any incidence of genetic or developed diseases in the following:

Maternal: Grandmother _____ Grandfather _____

Paternal: Grandmother _____ Grandfather _____

Mother _____ Father _____

Siblings _____

Other relatives with significant history (please indicate relation):

_____

Lifestyle

Does your child exercise? How often? _____

Any environmental hazards? Age of house, carpeted floors, air filtered, water type, cleaning products, close to industry, cigarette smoke, pets, etc.? _____

_____

Any allergies (food environmental, medications)? _____

Please describe the child's home life (ex. family structure, stress level in house, responsibilities/expectations, etc.)

_____

_____

_____

How is your child's attitude towards school? _____

Extracurricular activities _____

Please describe their typical day, including actions, feelings, energy and anything else you deem significant:

_____

How would you describe your child's interaction or socialization with others?

_____

Fears, causes of anxiety, sensitive issues? _____

_____

Previous (please indicate age) or current bedwetting _____

Nocturnal Events: (Dreams, Nightmares/Terrors, Sleep-Walking, Insomnia, etc.,)?

_____

REVIEW OF SYSTEMS

Circle Conditions That Apply or Have Had in The Past:

General (Fever, Illness, Hospitalization, Injury, Other:_____)

_____

Head (Swelling, Rash, Hair loss, Head injury, Other: _____)

_____

Eyes (Discharge, Redness, Infection, Eye injury, Other: _____)

_____

Ears (Discharge, Infection, Ear injury, Other: _____)

_____

Nose (Allergy, Discharge, Bleeding, Injury, Other: _____)

_____

Mouth (Lesion, Cavities, Swelling gums, Infection, Other: _____)

_____

Skin (Rash, Wart, Infection, Mole/Birth Mark, Other: _____)

Neck/Throat (Sore throat, Infection, Swollen glands, Other: _____)

_____

Respiration (Cough, Infection, Asthma, Wheeze, Other: _____)

_____

Heart (Cyanosis, Sweating, Circulation difficulty, Other: _____)

_____

GI (Allergy, Diarrhea, Constipation, Vomiting, Other: _____)

_____

Urinary (Rash, Erythema, Discharge, Hematuria, Frequency, Other:_____)

_____

Musc/Skel (Limited movement, Loss strength, Fracture, Other: _____)

_____

Nervous Sys (Tremor, Lethargy, Irritability, Seizure, H/A, Other: _____)

PHYSICAL EXAM-Doctors use only

General-mood, gait

Vitals- BP _____ L/ R arm sitting Pulse ____bpm RR _____ Temp _____ Wt _____lbs Ht (ft) _____

Skin- colour, temp, texture, moisture, mobility, turgor, lesions

Head-symmetry, lumps, lesions, tenderness, hair loss/texture, sinuses, clench,TMJ, light touch, expression, shrug

Neck-nodes, thyroid, swallow, tracheal deviation

Eyes-lids, brows, lashes, colour, edema, d/c, sclera, cornea, conjunctiva, visual fields, eye movements, nystagmus, convergence, accommodation, papillary reflex, cover/uncover, acuity, fundoscopy

Nose-lumps, tenderness, patency, acuity, mucosa (colour, vessels, septum, polyps)

Mouth-lips, gums, teeth, mucosa, glands, tonsils, pharynx, tongue, gag reflex

Ears-lesions, discharge, palpate (pinna, tragus, mastoid), finger rub, acuity, (Weber, Rinne), otoscopy

Thorax-spinal curvature, fremitus, expansion, percussion, excursion, kidney punch, auscultation, axillary nodes

Chest-carotids, thyroid, apical impulse, auscultate

Abdomen-lesions, auscultate (quadrants, arteries), percuss (quadrants, liver span, spleen), palpate (abd, liver, kid, inguinal nodes, aortic pulse), abd reflex

Extremities-symmetry, leg edema, temp, nails, cap refill, palpate pulses

Neuro MSK- ROM, grip strength, DTR, toe proprioception, stereognosis, graphesthesia, pain (sharp/dull), vibration, coordination (finger/nose), heel-to-toe, Rhomberg

ADDITIONAL INTAKE FOR ADOLESCENTS

General:

Tried smoking? _____
Recreational Drugs? _____
Alcohol (If yes, how many drinks a day/week)? _____
Sexually active? _____
Sexual preference (Heterosexual / Bisexual / Homosexual) _____
_____

Emotional: (circle ones that you have had or currently experiencing)
Depression / Mood Swings / Anxiety / Insomnia / Phobias

What are your Hobbies / Habits? _____
_____

Female:

Age of Menarche _____
Are cycles regular _____
Premenstrual symptoms _____
_____
Cravings during cycle _____
Length of cycle _____
Colour of flow _____
Pain during periods _____
Flow (excessive/scanty) _____
Last Menstrual period _____
Vaginal discharge/Flow between period _____
_____
Vaginal itching
Birth Control _____ If Yes, What type/form _____
_____
Number of Pregnancies? _____
How many live births? _____
How many miscarriages? _____
Sexual difficulties _____
Last PAP (date) _____
Last physical examination (date) _____

Male:

Hernias/Masses _____
Testicular pain _____
Sexual difficulties _____
Discharges or sores _____