Aurora Integrative Medical

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Pediatric Intake Questionnaire (Birth - 12 years)

Patient Information

Name: _____ _____ _____
(First) (Middle) (Last)

Date of Birth: (Month): _____ (Day):_____ (Year): _____ Age: _____ Sex: _____

Grade in school: _____ School: _____

Parent/Guardian Information

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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

Phone (home): _____ Phone (business): _____
Phone (mobile): _____ e-mail: _____

Child's GP or Pediatrician: _____ Phone : _____

What is the makeup of your child's household (eg. parents, siblings, etc.)? If multiple households, please describe: _____
_____

How did you hear about Aurora Integrative Medical?
☐ *Internet Search* ☐ *Friend* ☐ *Family* ☐ *Newspaper* ☐ *Other (please specify):* _____

Does your child have any known allergies to medications/foods/inhalants? Yes ☐ No ☐
If yes, please list:

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Confidential Health and Lifestyle Questionnaire

Please complete this questionnaire with care, as this will help us determine the most effective treatment plan for you.

What is the main reason for coming in?

What are your child's most important health concerns? (list in order of importance)

_____ _____

_____ _____

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

What long-term expectations do you have for your child's state of health?

Please list diagnoses and types of treatments your child has received:

_____

_____

Please list any medications, supplements, remedies, and herbal medicines your child is taking:

_____

_____

What do you feel is causing any health problems your child may have?

_____

MEDICAL HISTORY - please check all those that apply:

☐ Chicken pox	☐ Measles	☐ Mumps	☐ Whooping cough
☐ Strep throat	☐ Impetigo	☐ Ear infections	☐ Mononucleosis

Please list any serious injuries/hospitalizations/illness, with brief details:

_____

_____

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IMMUNIZATIONS - please check all those that apply:

☐ MMR ☐ DPT ☐ Polio ☐ Smallpox ☐ H. influenza B
☐ Hep A ☐ Hep B ☐ H1N1 ☐ Flu vaccine ☐ Other: _____

Any adverse reactions to vaccinations? ☐ Yes ☐ No If yes, please describe:

PRENATAL HISTORY

Mother's age at birth: _____ # of previous pregnancies: _____ Regular health check-ups: Y☐ N☐
Described mother's health during pregnancy: _____
Please check all that apply:
☐ Nausea/vomiting ☐ Medications ☐ High Blood Pressure ☐ Gestational diabetes
☐ Cigarettes/Alcohol/Drugs ☐ Illness ☐ Emotional trauma ☐ Post-partum depression

BIRTH HISTORY

Term: ☐ Full ☐ Premature (# weeks: _____) ☐ Late (# weeks: _____)
Birth: ☐ Vaginal ☐ C-section ☐ Induced ☐ Anesthesia used

Please list any birth complications: _____
Feeding: Breastfed? Y☐ N☐ How long: _____ Formula? Y☐ N☐ ype: _____

Age your child began: Sitting up _____ Crawling _____ Walking _____ Talking _____

HEALTH OVERVIEW

Current weight: _____ Height: _____Blood type: _____

Allergies (food, environmental): _____
Dietary restrictions: _____

Regular bowel movements? Y/N How much water does your child drink daily: _____
Regular exercise? Y / N Please describe: _____
Sleep: # Hours per night: _____ Bedtime: _____ Awake at: _____ Naps? Y☐ N☐

Please describe your child's temperament: _____

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Review of Symptoms

Please indicate any current or significant past symptoms your child is experiencing.

General
- ☐ Headaches
- ☐ Appetite changes
- ☐ Weight change ↑☐↓☐ ___lbs
- ☐ Poor sleep
- ☐ Fatigue
- ☐ Chills and fevers
- ☐ Night sweats
- ☐ Sweating - excess or lack
- ☐ Delayed speech
- ☐ Delayed development
- ☐ Diagnosed learning disability: _____

Skin and Hair
- ☐ Rashes ; Itching ; Hives
- ☐ Eczema
- ☐ Acne, boils
- ☐ Loss of hair ; Dandruff
- ☐ Irregular moles

Eyes Ears Nose Throat
- ☐ Impaired hearing
- ☐ Ear aches ; infections
- ☐ Ringing in ears
- ☐ Ear wax build up
- ☐ Sinus infections
- ☐ Sore throats / tonsillitis
- ☐ Nosebleeds
- ☐ Itchy / red eyes
- ☐ Mercury fillings? #_____?
- ☐ Canker sores

Cardiovascular
- ☐ Heart murmur
- ☐ Easy bruising / bleeding
- ☐ Cold hands or feet

Muscles, Bones & Joints
- ☐ Pain / cramps
- ☐ Muscle weakness

Respiratory
- ☐ Hayfever
- ☐ Difficulty breathing
- ☐ Chronic cough
- ☐ Sputum
- ☐ Pneumonia / Bronchitis
- ☐ Asthma
- ☐ Coughing blood
- ☐ Wheezing

Liver
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Indigestion of fatty food
- ☐ Sensitive to fumes / chemicals / smells
- ☐ Brown spots on skin

Gastrointestinal
- ☐ Indigestion / Heartburn
- ☐ Gas or burping
- ☐ Constipation
- ☐ Diarrhea
- ☐ Abdominal pains / colic

Colon Flora/Leaky Gut
- ☐ Itching or burning anus
- ☐ Yeast infections / thrush
- ☐ Antibiotic use
- ☐ Frequent illness
- ☐ Autoimmune disease (family or self)
- ☐ High dairy intake

Neurological
- ☐ Poor memory
- ☐ Dizziness
- ☐ Lack of coordination
- ☐ Seizures
- ☐ Concussion
- ☐ Numbness - hands / feet

Adrenals
- ☐ Frequent illness / colds
- ☐ Easily exhausted
- ☐ Under a lot of stress?
- ☐ Tired in afternoon
- ☐ Crave salt
- ☐ Crave sugar / sweets
- ☐ Dark circles under eyes

Genito-Urinary
- ☐ Frequent / urgent urination
- ☐ Pain on urination
- ☐ Urinary tract infections
- ☐ Wake at night to urinate
- ☐ Incontinence
- ☐ Infections
- ☐ Blood in urine
- ☐ Bedwetting

Emotional
- ☐ Depression
- ☐ Irritable
- ☐ Mood swings
- ☐ Anxiety
- ☐ Diagnosed mental illness
- ☐ Insomnia
- ☐ Nightmares
- ☐ Antisocial behaviour
- ☐ Unusual fears
- ☐ Problems with peers
- ☐ Problems with schoolwork

Male
- ☐ Testicular pain or mass
- ☐ Paraphimosis / Phimosis

Female
- ☐ Early onset menstruation
- ☐ Vaginal discharge

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Family History

Please list health history of family members including conditions such as cancer, diabetes, celiac, stroke, mental illness, arthritis, asthma, learning disability etc.

Family Member	Age if Alive	Age at Death	Conditions
Mother			
Maternal Grandmother			
Maternal Grandfather			
Father			
Paternal Grandmother			
Paternal Grandfather			
Siblings			

Treatment

What behaviors or lifestyle habits do you and your child currently engage in regularly that you believe **support** your child's health? (please list)

_____

_____

What behaviors or lifestyle habits do you and your child currently engage in regularly that you believe are **self-destructive** to your child's lifestyle: (please list)

_____

_____

What does your child **LOVE** to do? What are his/her hobbies and interests?

_____

_____

_____