

**FLORES HEALTH SERVICES INC.**

Dr. Luis Flores, RCSHom

Dr. Rikst Attema, ND

**PEDIATRIC INTAKE FORM**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Birthdate (dd/mm/yr) \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_

Email: \_\_\_\_\_

Mailing Address:

\_\_\_\_\_  
\_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

\_\_\_\_\_

How did you hear about our clinic?

\_\_\_\_\_

**CURRENT HEALTH PROBLEMS / MAIN HEALTH CONCERNS**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

**CHILD'S PAST MEDICAL HISTORY (Surgeries, Hospitalizations)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IMMUNIZATIONS** (provide the dates for the ones your child has had):

_____ Measles	_____ Mumps	_____ Rubella
_____ Diptheria	_____ Pertussis	_____ Tetanus
_____ Polio	_____ Influenza	_____ Smallpox
_____ Hepatitis A	_____ Hepatitis B	_____ Hib
_____ Meningitis C	_____ BCG (TB)	_____ Cholera
_____ Typhoid	_____ Yellow Fever	_____ Rabies
_____ Whooping cough	_____ Pneumococcus	

Immunization reactions:

\_\_\_\_\_

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**ALLERGIES (please list any known or suspected allergies/sensitivities to the following)**

Drugs/Medications: \_\_\_\_\_

Foods \_\_\_\_\_

Environmental (ie. Dust, animals, trees, chemical)  
\_\_\_\_\_

**CHILDHOOD ILLNESSES (please check)**

\_\_\_\_\_ Chickenpox

\_\_\_\_\_ Scarlet Fever

\_\_\_\_\_ Pneumonia

\_\_\_\_\_ Ear Infections

\_\_\_\_\_ Measles

\_\_\_\_\_ Mumps

\_\_\_\_\_ Rubella

\_\_\_\_\_ Allergies

\_\_\_\_\_ Rheumatic Fever

\_\_\_\_\_ Frequent Colds

\_\_\_\_\_ Tonsillitis

**CHILD'S SYMPTOMS (checkmark if current, use P for past symptoms):**

\_\_\_\_\_ eczema

\_\_\_\_\_ burning urine

\_\_\_\_\_ nervous

\_\_\_\_\_ fatigue

\_\_\_\_\_ nose bleeds

\_\_\_\_\_ frequent urination

\_\_\_\_\_ cries easily

\_\_\_\_\_ cough

\_\_\_\_\_ bed wetting

\_\_\_\_\_ sleep problems

\_\_\_\_\_ diarrhea

\_\_\_\_\_ unusual fears

\_\_\_\_\_ blood in urine

\_\_\_\_\_ night sweats

\_\_\_\_\_ constipation

\_\_\_\_\_ stomach aches

\_\_\_\_\_ sore throats

\_\_\_\_\_ wheezing

\_\_\_\_\_ appetite change

\_\_\_\_\_ hearing loss

\_\_\_\_\_ body/breath odour

\_\_\_\_\_ frequent vomiting

\_\_\_\_\_ dizzy spells

\_\_\_\_\_ hair loss

\_\_\_\_\_ tendency to bleed

**FAMILY HEALTH HISTORY (check appropriate boxes)**

\_\_\_\_\_ allergies/asthma

\_\_\_\_\_ arthritis

\_\_\_\_\_ cancer

\_\_\_\_\_ diabetes

\_\_\_\_\_ birth defects

\_\_\_\_\_ heart disease

\_\_\_\_\_ hypertension

\_\_\_\_\_ mental illness

Please specify any other relevant family history: \_\_\_\_\_

**BIRTH HISTORY**

Child's Weight at Birth: \_\_\_\_\_

Term (premature, full, late) \_\_\_\_\_

How many weeks of gestation? \_\_\_\_\_

Type of delivery (C-section, vaginal, use of forceps) \_\_\_\_\_

Complications/details \_\_\_\_\_

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**PRENATAL HISTORY**

Mother's age at child's birth \_\_\_\_\_

Mother's health during pregnancy (check appropriate box):

- bleeding                       hypertension                       medications
- nausea                               illnesses                               diabetes
- thyroid problems               cigarettes/drugs/alcohol consumption
- physical/emotional trauma

Did your infant experience any of the following at birth or soon after? (please check)

- jaundice                               colic                                       seizures
- birth defects                       birth injuries                               rashes

Other:

\_\_\_\_\_

**GENERAL INFORMATION**

Breast Fed (y/n) \_\_\_\_\_ How long: \_\_\_\_\_

Formula (y/n) \_\_\_\_\_ If Y, Type (milk, soy, rice other) \_\_\_\_\_

Age that your child began:

- solid foods                               sitting                                       smiling
- crawling                                       walking                                       first words

**MEDICATIONS/SUPPLEMENTS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If there is any additional information that may be relevant please add here:

\_\_\_\_\_  
\_\_\_\_\_

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