IMI – Integrated Medicine Institute

CHILD INTAKE FORM (0-12 yrs)

Name: ____

(LAST) (FIRST) (MIDDLE)

Date of Birth: _____________ Gender: ____ Weight: ____ Height: ____

YEAR/ MONTH/ DAY

Mother's Name: _________________________

Father's Name: _________________________

Home Address:

____

____

Home Phone Number (incl. area code): __________________

Parent/ Guardian's Work or Mobile Number (incl. area code): __________________

May we leave messages pertaining to the child's health over the phone? Yes / No

In case of emergency, we should contact:

Name: ______________________ Phone Number (incl. area code): __________________

Relation: ____________________ Other Contact # (if applicable): ___________________

Pediatrician/Medical Doctor's Information

Name ______________________

Phone Number ______________________

Address ______________________

____

How did you hear about IMI? ____

*If you were referred to us by a friend or family member, please give us their name so we may send them a letter of thanks. ____

We send newsletters on health issues and other information mailings to all our patients. If you do NOT want to be part of the mailing list, please check here: "No thank you" _

Who is filling out this form (name and relation)? ________________________________

Child's Health Concern(s), in order of importance:

1)___________________________

2)___________________________

3)___________________________

4)___________________________

Mother's Profile

Age of Mother: _____

Present Health Status (circle): Excellent/ Good/ Fair/ Poor

Any Medical-Surgical Events Prior to Pregnancy (none or list): ______________________________

Are you a smoker? Yes / No If yes, indicate how many cigarettes per day: _____

Do you consume any alcohol? Yes / No If yes, indicate how much per week: _____

Are you working presently? Yes / No If yes, circle FULL-TIME / PART-TIME

What is your stress level? Please rate on a scale of 1 (least) to 10 (most). ________

Prenatal history:

Duration of Pregnancy (weeks of gestation): _____________

How was the child conceived (circle)? Natural/ In-Vitro Fertilization (IVF)/ Other: __________

List any illnesses, infections, complications during pregnancy:
____

Treatments/ Medications During Pregnancy (check):
_ Tobacco _ Alcohol _ Recreational Drugs: List _____________________
_ Prescription/ Over-The-Counter Drugs: ____________________________________
_ Supplements/ Others: ____

Describe your diet during the pregnancy. Indicate cravings also.
____

How much weight did you gain? ________

Did you experience any of the following during the pregnancy (check):
_ nausea _ vomiting _ high blood pressure _ physical/ emotional trauma
_ diabetes _ other ____

Any past miscarriages? Yes / No If yes, when: _______________________________________

Labor and Delivery History:

Birth Weight: _____ Birth Height: _____ Duration of Labor: _____
Type of Delivery (natural vaginal / C-section):________________________
Medications and Anesthesia (types, durations, any reactions):
____
Were any of the following used?
_ episiotomy _ forceps _ vacuum _ epidural _ other: __________________
Any complications (none or list)?
____
Delivery attended by father? Yes / No
Was baby held/ nursed on delivery table? Yes / No
APGAR score (leave blank if unknown): _____
Any congenital abnormalities (none or list): _____________________________________

Father's Profile

Age of Father: _____
Present Health Status (circle): Excellent/ Good/ Fair/ Poor

Any Prior Medical-Surgical Events (none or list): _______________________________
Are you a smoker? Yes / No If yes, indicate how many cigarettes per day: _____
Do you consume any alcohol? Yes / No If yes, indicate how much per week: _____
Are you working presently? Yes / No If yes, circle FULL-TIME / PART-TIME
What is your stress level? Please rate on a scale of 1 (least) to 10 (most). ________

Child's Profile

A. Medical History:

Any medical conditions (illnesses, injuries, etc.) (If in past, please provide date):
Past __________________ Present __________________
__________________ __________________

Childhood Illnesses:
If child has had any of the following in the past, please provide date of occurrence.

Name	Date
Rubella	
Measles	
Mumps	
Roseola	
Chicken Pox	
Strep Throat	
Rheumatic Fever	
Scarlet Fever	
Impetigo	
Ear Infections (also state how often)	

Current and Past Medications and Supplements (indicate brand and dose, for how long):
____
____
____

Vaccination History (check and provide date):
_ DPT (diphtheria, pertussis, tetanus), when: _________________
_ Tetanus booster, when: ______________
_ MMR (measles, mumps, rubella), when: ________________
_ Polio, when: _______________
_ Flu shot, when: ________________
_ Haemophilus influenza B, when: ________________
_ Hepatitis A, when: _______________
_ Hepatitis B, when: _______________
_ Others: ____
List any adverse reactions:
____

Accidents and injuries (what and when):
____
Hospitalizations and surgeries (for what reason and when):
____
Does your child have any allergies? (medicines, environment, etc.)
____

B. Feeding/ Nutritional History:
- breastfed for how long: __________
- formula at what age: __________ what kind (milk, soy, other): __________________
- reaction to any formulas? Yes / No If yes, describe: ______________________

Food Introduction Schedule:
- List foods that were introduced and at which month/ year of age:

Age of Food Introduction				
Type of Food (fruit, meat, etc.) Introduced				

Describe your child's appetite:
____

Please give a 24-hr diet recall for the child:
Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____

Cups of water in a day: ___________
Food preferences and dislikes? ____

C. Sleeping Patterns:
When does the child go to bed? ________ When does he/she wake up? ________
Does the child wake up in the night? Yes / No If yes, how often: ______________
Does your child take naps? Yes / No If yes, how long are naps: ______________

D. Developmental milestones:
When did the child first: sit up _______ crawl _______ walk ________ talk ________
be fully toilet- trained _________ brush own teeth _________

E. Family History (include chronic, inherited conditions, allergies, causes of death, illnesses):

Relative	*Condition(s)*
Mother	
Father	
Sibling #1	
Sibling #2	
Sibling #3	
Sibling #4	
Grandparents	
Other	

F. Psychosocial/ Overall Health:
Child's Hobbies and Enjoyed Activities:
____
____
How often does your child watch TV/ play video games?(fill in # & circle day or wk) ___ hrs a day/ wk
Is your child in (check): _ school _ daycare _ other _________________________
Current School: ____
Grade: _____________
How would you describe your child's performance and behaviour at school?
____
Does your child exercise regularly? Yes / No If yes, what type of exercise, how much and how often:
____

Home/ Environment Profile

Position of child in family: ____________
Number of people in the home: ___________________

Who is (are) the primary caregiver(s)? _____________________________
Other caretakers for child: ____
Does anyone in the home smoke? Yes / No
Do you know of any toxins or hazards that your child is exposed to regularly (home, hobbies, etc.)?
____
Any pets in the home? Yes / No If yes, list: ___________________________________

How old is the house the family is living in? ____________________
Has it been recently renovated? Yes / No

Review of Systems
Circle any symptom(s) child has experienced and put an ***N*** beside it if currently experiencing it **now** or ***P*** if in the **past**.

General: headache fever/ chills fatigue/ weakness dizziness

Hair and Scalp: dandruff lice cradle cap itchiness hair loss

Skin: infections rashes scaling bruising bleeding

Eyes: infections blurred vision eyeglasses (nearsighted, farsighted) squinting color blindness

Ears: infection discharge wax decreased hearing foreign objects

Nose, throat, sinuses: runny nose colds decreased smell foreign objects bloody nose tonsillitis

Mouth and dentition: cavities gingivitis cleft lip

Respiratory: bronchitis pneumonia asthma cough sputum

Cardiovascular: heart murmurs cyanosis palpitations rheumatic fever

Gastrointestinal: nausea vomiting diarrhea constipation jaundice colic gas anorexia blood in stool

Urinary: increased frequency urgency burning bedwetting odor blood in urine hesitancy

Male Reproductive: hernias testicular mass testicular pain penile discharge

Female Reproductive: menses vaginal itching vaginal discharge

Neuromuscular: seizures muscle weakness numbness tremors imbalance

Blood/ Lymphatics: anemia easy bleeding easy bruising swollen lymph node

Emotional: mood swings nervousness depression/ sadness

Thank you for taking the time to complete this form.