Maxum Health Clinic
Unit 307,
385 Silver Star Blvd
Scarborough, Ontario
M1V 0E3

Pediatric Intake Form

Patient Information

Date_____

Name_____

Address_____

_____

Age _____ DOB _____

Contact Email: _____

May we contact you by email? Yes ⊙ No ○

Name of Parent or Guardian:

Name_____

Relation_____

Phone_____

Name of Alternate Parent or Guardian:

Name_____

Relation_____

Phone_____

Health History

What are the child's primary health concerns or treatment goals?

1)_____

2)_____

3)_____

Please list any current medications or supplements the child may be taking:

_____

_____

_____

Please list any previous hospitalizations, surgeries, or significant illnesses:

_____

_____

General Diet:

Vegetarian Vegan Omnivore Other

Please check any conditions that have occurred in family members:

- ❑ Diabetes
- ❑ Arthritis
- ❑ High Blood Pressure
- ❑ Cardiovascular Disease
- ❑ Cancer
- ❑ Mental Health Conditions

Other_____

Please check any conditions the child has, or has had in the past:

- ❑ Anemia
- ❑ Allergies or sensitivities: _____
- ❑ Arthritis
- ❑ Cancer
- ❑ Diabetes
- ❑ HIV
- ❑ Hepatitis
- ❑ Mental Health Conditions: _____

Please check any general symptoms the child has experienced in the past year:

- ❑ Notable weight loss or gain
- ❑ Irritability
- ❑ Nervousness or anxiety
- ❑ Excessive Fear
- ❑ Excessive Anger
- ❑ Excessive Worry
- ❑ Excessive Joy
- ❑ Easily Startled
- ❑ Headaches / Migraines
- ❑ Notable Hair Loss
- ❑ Fatigue
- ❑ Difficulty Focusing
- ❑ Poor Memory or Concentration
- ❑ Night Sweats or Excessive Sweating

How would you currently rate the child's energy levels ☐ Low 0—1—2—3—4—5—6—7—8—9—10 High

Review of Systems

Please check any Symptoms the child has experienced at <u>any point in their history:</u>

Musculoskeletal:
- ❑ Tremors or Cramps
- ❑ Swollen Joints
- ❑ Pain or Weakness of Muscles

Cardiovascular:
- ❑ Chest Pain
- ❑ Poor Circulation
- ❑ Swelling of Hands, Ankles, Feet
- ❑ Irregular Heart Beats
- ❑ Dizziness or Shortness of Breath

Eyes, Ears, Nose, Throat, Respiratory:
- ❑ Asthma or Wheezing
- ❑ Allergies
- ❑ Blurred Vision or Visual Changes
- ❑ Eye Pain
- ❑ Loss of Hearing
- ❑ Earaches / Ear Infections
- ❑ Ringing in the Ears
- ❑ Sore Throat

Immune:
- ❑ Frequent Colds, Flus, or Infections
- ❑ Swollen Glands
- ❑ Long Recovery Following Infections

Skin:
- ❑ Poor Wound Healing
- ❑ Rashes
- ❑ Eczema
- ❑ Psoriasis
- ❑ Easy or Unexplained Bruising
- ❑ Itching
- ❑ Dryness
- ❑ Frequent or Recurring Skin Infections

Digestion:
- ❑ Gas or Bloating
- ❑ Abdominal Pain or Cramping
- ❑ Heartburn / Acid Reflux
- ❑ Difficulty Swallowing
- ❑ Nausea or Vomiting
- ❑ Poor Appetite
- ❑ Excessive Appetite
- ❑ Loose Stools or Diarrhea
- ❑ Undigested Food in Stool
- ❑ Blood or Mucus in the Stool
- ❑ Constipation or Difficulty Passing Stool
- ❑ Irregular Bowel Movements
- ❑ Pain or Itching of the Anus

Sleep:
- ❑ Difficulties Falling Asleep
- ❑ Difficulties Staying Asleep
- ❑ Waking Unrefreshed
- ❑ Excessive Dreaming or Nightmares

Genitourinary:
- ❑ Blood or Mucus in Urine
- ❑ Frequent Urination
- ❑ Difficulty Controlling Urine
- ❑ Bedwetting
- ❑ Urgency
- ❑ Bladder Infections

Maternal/Prenatal Health:

Term length in weeks _____

Birth weight _____

Type of Birth ⊙ Vaginal ○ C-Section

Was labour induced? ⊙ No ○ Yes

Was/is the child breastfed? ☐ No How long_____

Please list any pharmaceutical or recreational drugs taken by the mother during the pregnancy, including tobacco and alcohol:

_____

_____

_____

Has the child been treated with antibiotics? No

How often? _____

Please check the child's immunizations:

- ❑ MMR (Measles, Mumps, Rubella)
- ❑ DPT (Diphtheria, Pertussis, Tetanus)
- ❑ Influenza (Flu shot)
- ❑ Chickenpox
- ❑ Hep A
- ❑ Hep B
- ❑ Tetanus (as a single)

Others _____

Please list any health concerns or information not otherwise mentioned:

_____

_____

_____

Consent to Treatment

I attest that the information provided on this form is correct to the best of my knowledge, and I consent to the treatment as I understand it. I understand that I am free to ask questions, and that I may withdraw my consent at any time.

Signature_____ Date_____