Dr. Nadine Cyr N.D.

Pediatric Intake *(Birth to 12 years)*

Patient's Name: _____ Age: _____ Sex: _____Date of Birth: _____
Mother's Name: _____ Father's Name: _____
Phone # _____ email: _____
Referred by: _____

Presenting Health Concerns:

_____
_____
_____

Childhood Illnesses:

Allergies ____Asthma____Bronchitis ____ Chicken Pox ____ Croup____ Ear Infections ____
Frequent Cold/Flu ____Pneumonia____ Tonsillitis____Whooping Cough____Bladder Infections _____
Others: _____

Has your child had any of the following tests? Results:

Electroencephalogram: _____ _____
Psychological Evaluation: _____ _____
Hearing: _____ _____
Speech/Language: _____ _____

Injuries/Surgeries/Hospitalizations (please list):

_____
_____

Immunizations:

DPT ___ Hep B ___ Men-C ___ Hib ___ Chicken Pox ___ Flu ___ MMR ___ Pneumo ___
Others: _____
Tylenol given before and/or after vaccines? Yes No
Adverse reactions to any vaccine? _____

Child's Medication History:

Antacids (Losec, Zantac) _____Antibiotics _____# of times: _____ Anti-Histamines ____
Bronchodilators/Puffers _____Hydrocortisone Creams _____ Tylenol _____ Seizure medication____
Others: _____

Family History (parents, siblings, grandparents):

Alcoholism ___ Allergies ___ Arthritis ___ Asthma ___ Birth Defects ___ Cancer ___ Diabetes I or II ___ Heart Disease ___ Mental Illness ___ Thyroid disorders ___ Ulcerative Colitis/Crohns ___ Birth Defects __

Prenatal Health History

Health of the parents at time of conception:

Mother: Poor ___ Fair ___ Good ___ Excellent ___ Unknown ___
Father: Poor ___ Fair ___ Good ___ Excellent ___ Unknown ___
Mother's age at child's birth ____ Previous pregnancies (#) ____ Miscarriages (#) ____
Conception History: IUI ____ IVF _____ Egg Donor ____ Sperm Donor____

Mother's health during pregnancy:

Bleeding ____ Physical or Emotional Trauma ____ Diabetes _____ Nausea / vomiting ____ Hypertension _____ Cigarettes, alcohol, drug consumption ____ Anemia _____ Recurrent Illnesses ____ Thyroid imbalances ____ Hypertension _____
Mother's diet during pregnancy:
Poor ___ Fair ___ Good ___ Excellent ___ Unknown ___

Medications taken during pregnancy: _____

Birth History:

Term: Premature ____(wks) Full ____ Late ____ (wks)
Induced Labor? ____ Length of Labor: ____ (hrs)
Epidural: Yes No Antibiotics: Yes No
Delivery: Vaginal ___ C-Section ___ Forceps ___ Vacuum _____
Birth weight: ____ Jaundice: _____ Birth Injuries: _____ NICU: Yes No
Complications: _____

Breast Fed? _____ How long? _____ Complications? _____
Formula? _____ *milk or soy or other* Began at what age? _____Intolerances to formula? ____
Did your child experience colic? Yes No Was it ___ Mild ___ Moderate ___ Severe _____
Solids Introduction ____months First Food: _____ Adverse reactions: _____
Food Intolerance (if known): _____

Mother's Health Post-Partum:

Depression _____ non-medicated _____ medicated _____ medication used: _____
Excessive bleeding ____ Retained placenta ____

Milestones:

Sitting _____(mths) Crawling _____(mths) Walking ____ (mths) First Words _____(mths)

Sleep Patterns:

1st year: good / fair / poor
Current: good / fair / poor
Current Bedtime:
Sleeps in dark room ___sleeps with night light __

Symptoms: Mark (C) for Current and (P) for Past symptoms:

___ Eczema	___ Hives	___ Dry skin	___ Chronic Rash
___ Sore Throats	___ Cough	___ Frequent colds	___ Nose bleeds
___ Stuffiness	___ Bronchitis	___ Asthma	___ Pneumonia
___ Wheezing	___ Allergies	___ Strep Throat	___ High Fevers
___ Hearing loss	___ Tubes	___ Cavities	___ Vomiting spells
___ Body odour	___ Bleeding gums	___ No appetite	___ Failure to thrive
___ Broken bones	___ Muscle cramps	___ Muscle weakness	___ Joint pains
___ Low muscle tone	___ Colic	___ Constipation	___ Diarrhea
___ Food Allergy	___ Parasites	___ Gas	___ Stomach aches
___ Teeth grinding	___ Weight loss	___ Bed wetting	___ Nightmares
___ Night terrors	___ Night sweats	___ Sensitive to lights	___ Sensitive to noise
___ Fatigue	___ Cries easily	___ Headaches	___ Anxiousness
___ Unusual fears	___ Bruises easily	___ Nosebleeds	___ Seizures
___ Anemia	___ Excessive thirst	___ Excessive hunger	___ Bladder infection
___ Painful urination	___ Frequent urination	___ Inability to hold urine	___ Hyperactivity
___ Attention deficit	___ Mood swings	___ Autism / ASD	___ Head injury

Place a check mark next to the characteristics that best describe your child:

___ Prone to eye and/or ear discharge	___ Eyes are sensitive to light
___ Sweats from head when sleeping	___ Sweats from feet
___ Skin is slow to heal	___ Prefers sweet foods
___ Prefers salty foods	___ Cries easily
___ Prefers cold drinks and food	___ Prefers warm drinks and food
___ Sensitivity to odours	___ Prefers hot weather/summer
___ Prefers cold weather/winter	___ Wants to be consoled when upset
___ Prefers to be alone when upset	___ Is very self-confident
___ Lacks self-confidence / is shy, reserved	___ Has had injury to spine
___ Has experienced physical trauma	___ Has experienced emotional trauma / stress
___ Easily adapts to change, new situations	___ Has difficulty adapting to change, new situations
___ Is generally happy	___ Seems to be angry or frustrated often
___ Loves to play outdoors	___ Loves animals, is very kind to them
___ Has a fear of animals	___ Is generally fearful
___ Is adventurous, fearless	___ Loves music and/or dance
___ Prefers to play alone	___ Prefers to play with a group of friends
___ Makes friends easily	___ Was a late walker or talker
___ Has met most development milestones early (walking, teething, talking)	
___ Skin is sensitive to fabrics	___ Is sensitive to noise

Others: _____