Axiom Health
202 – 2900 PANDOSY ST., Kelowna, BC V1Y 1V9

PEDIATRIC INTAKE FORM

Patient Info:
First Name:__________________________ Last Name:_____________________
Age:________________________________Sex:__________________________
Address:____
Phone:_________________ DOB: _________
Referral:___________________________
Guardian(s):______________________________
Person who is filling out this form: _____________________________
Relation:___________________

Contacts Name:___________________
Phone:__________________
Relation:________________

Other health care practitioners
Name:___________________ Name:_____________________________
Phone:___________________ Phone:_____________________________

Child's Health Concerns in order of importance:
1. ____
2. ____
3. ____
4. ____
5. ____

Present Medical Information:
Height:____________ Weight:________________

Past Medical History

Conception:
Mother health: __________________
Father health: ___________________
Number of Previous Pregnancies: _____ Number of miscarriages: ______
Abortions:_________________________
Any medical interventions (medication, artificial insemination, etc.) ________________
____

Axiom Health
202 – 2900 PANDOSY ST., Kelowna, BC V1Y 1V9

Pregnancy
Pregnancy length:________________ Weight gain:_____________
Mother's age:________
Illness or infections during:_______________________ medication associated:________
Toxic exposures:____________________ Travel:________________________
Stress:____________________________ Work:_____________ when stopped:___________
Diet:_____________________________ Cravings: _________________________________
Conditions associated:
Other:____
Pre-natal care by:_________________________Supplementation:______________________
Medications (Rx and OTC):____

Labour
Labour length:__________________ Complications:___________________
Birth:____________________
Medications administered:___________________________________

Infancy
Birth weight:___________ height:________ length:__________ head circumference: ________
APGAR score: ______________
Natal disease: ______________________ Hospitalization associated:__________________
Breast fed: _____ how long?________ Problems associated: _____________________
Formula: ________ how long?____________ Any reactions: _______________________
Any adverse reactions with food introduction: _______________________________

Milestones (ages)
Sitting up:_____________________________Crawling:_________________
Talking:______________________________Walking:__________________
Teething:_____________________________Sentences:_________________

Childhood Illnesses:
Health as a child: (1) Poor to (10) Excellent__________ Explanation: _________________
___ Rheumatic fever ___ German Measles ___ Polio
___Allergies ___ Chicken pox ___ Mumps
___ Asthma ___ Ear infections ___ Skin conditions

Vaccinations: (please check all that apply)
( ) DPTP (Diphtheria, Pertussis, Tetanus, Polio)
( ) Booster (usually DT)
( ) Chicken pox
( ) MMR (Measles, Mumps, Rubella)
( ) HBV (Hepatitis B Vaccine)
( ) Other (flu shot, etc)
( ) Meningococcal
( ) Pneumococcal
( ) H. Influenza B
( ) HPV
( ) Shingles

Axiom Health

202 – 2900 PANDOSY ST., Kelowna, BC V1Y 1V9

Family History:

Has anyone in your immediate family had any of the following:

___Cancer	___High blood pressure	___Diabetes
___Heart Disease	___Allergies	___Arthritis
___Epilepsy	___Glaucoma	___Mental Illness
___Alcoholism	___Stroke	___Obesity

Other

____

____