



487 Davie Street, Vancouver, BC V6B2G2 Phone (604) 697-0397 Fax (604) 697-0883

PEDIATRIC INTAKE FORM (6 to 12 years)

Patient's name: _____ Date of first visit: _____

Age: _____ Date of Birth (month/day/year): ____/____/____ Gender: female male

Mother's name: _____ Father's name: _____

Address: _____ City: _____ Province: ____ Postal Code: _____

Phone number (home): (____) _____ Parent's work phone number (____) _____

Parent's e-mail address: _____

How did you hear about Sage Clinic? _____

Child's GP or Pediatrician: _____

Child's medical specialist(s): _____

Current health concerns: _____

MEDICAL HISTORY

_____ Chicken pox	_____ Scarlet fever	_____ Roseola	_____ Mononucleosis
_____ Measles	_____ Pneumonia	_____ Strep throat	_____ Impetigo
_____ Mumps	_____ Whooping Cough	_____ Ear Infections	
_____ Rubella	_____ Rheumatic fever	_____ other (please list) _____	

What screening tests has your child had? (blood, hearing, vision, etc) _____

Serious Illnesses/Injuries/Surgeries/Hospitalizations (please list): _____

Please list all current medications (prescription, over the counter, vitamins, herbs, homeopathics, etc.) _____

Has your child been treated with antibiotics? yes no If yes, how many times: ____ Most recent date: _____

Please list any other past prescription medications: _____

IMMUNIZATIONS

_____ MMR	_____ Polio	_____ MMR	_____ Smallpox	_____ H. Influenza B
_____ DPT	_____ Influenza	_____ Hepatitis B	_____ Hepatitis A	_____ Other: _____

Any adverse reactions to vaccines: yes no If yes, please describe: _____

FAMILY HISTORY (if known)

_____ Heart disease	_____ Diabetes	_____ Birth abnormality	_____ Celiac disease	Other: _____
_____ Hypertension	_____ Arthritis	_____ Tuberculosis	_____ Eczema	Other: _____
_____ Cancer	_____ Allergies	_____ Mental illness	_____ Asthma	Other: _____

Child's sleep patterns _____

How would you describe your child's temperament? _____

How would you describe your child's behavior and performance at school? _____

Does your child exercise regularly? yes no If yes, how often? _____

Food or environmental allergies (if known) _____

Any dietary restrictions (religious, vegetarian, vegan, etc.)? _____

Describe child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages (type and quantity) _____

SYMPTOMS (mark **Y** if current, **P** significant past symptom)

- | | | |
|---|---|--|
| <input type="checkbox"/> Hives | <input type="checkbox"/> Burning of urine | <input type="checkbox"/> Bloody urine |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Cries easily |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Vomiting spells | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Anemia | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> High fevers | <input type="checkbox"/> Stomach aches | <input type="checkbox"/> Sensitive to light |
| <input type="checkbox"/> Chronic rash | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Body/breath odor |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Motion/car sickness |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Flat feet | <input type="checkbox"/> No appetite |
| <input type="checkbox"/> Sore throats | <input type="checkbox"/> Constipation | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Gas | <input type="checkbox"/> Canker sores |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Unusual fears |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Joint pains | <input type="checkbox"/> Excessive fatigue |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Dizzy spells | <input type="checkbox"/> Hair loss |

Other: _____

What expectations do you have from this visit to our clinic?

What long-term expectations do you have for working with our clinic?

CONSENT AND CANCELLATION POLICY

I hereby consent to receive treatment by the practitioners of Sage Clinic. I understand that I am responsible for paying the full cost of treatment if I do not give 24 hours notice of change or cancellation.

EMAIL CORRESPONDENCE (we will not sell, rent, or share your email address)

Yes **No** - I would like to receive Sage Clinic's free monthly email newsletter, which contains information about clinic events, health conditions, current health news, and inspiring health quotations.

Yes **No** - Sage Clinic may correspond with me at the above email address.

Signature: _____ **Today's date:** _____
(Parent or Guardian)

Thank you. We look forward to helping your child in any way we can.