



West Vancouver Wellness Centre

#103-565 17th Street,
West Vancouver, BC
V7V 3S9

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www.healthydoc.com

Pediatric Intake Questionnaire

Please help us provide you with a complete evaluation by carefully filling out this questionnaire. All of your answers will be held *absolutely confidential*. If you have questions, please ask. Thank you.

Today's Date (Mo/Day/Year) _____

Name of Child: _____ Age: _____ M F Birth Date (Mo/Day/Year) _____

Parent's Name (or Legal Guradrian): _____ Sibling's (Name/Age) _____

Home Address: _____ City: _____ Postal Code _____

Home Phone# _____ Work phone # _____ Cellular phone # _____

Who referred you to the *West Vancouver Wellness Centre*? _____

Names of Other Healthcare Providers:

Medical Doctor _____ Specialist _____

Naturopathic Physician _____ Chiropractor _____

CURRENT HEALTH CONCERN(S)

When did the concern(s) begin (be specific)? _____

Have you been given any diagnosis? If so, what? _____

What measures have you taken to improve the condition(s)? _____

CURRENT MEDICATIONS (Prescriptions, Over the Counter Drugs, Nutritional supplements)

1) _____ Dosage: _____ 3) _____ Dosage: _____

2) _____ Dosage: _____ 4) _____ Dosage: _____

EARLY CHILDHOOD HEALTH HISTORY

Measles/Mumps/Rubella

Ear Infections

Asthma

Chicken Pox

Skin conditions

Bronchits

Fever

Other (please list and date) _____

Hospitalizations or Surgeries (date): _____

Significant Trauma (falls, injuries, etc.) _____

Birth Process (prolonged labour, forceps , epidural, vacuum etc.) _____

Allergies (drugs, chemicals, environmental, foods) _____

Vaccinations: (Check all applicable and list Date any Adverse Reactions) _____

D-PTP (Diphtheria, Pertussis, Tetanus, Polio)		Hib (H. influenza, often given with D-PTP)	
MMR (Measles, Mumps, Rubella)		Td + P (Tetanus, Diphtheria, Polio)	
OPV (oral polio vaccine)		Hepatitis B	
Flu shot			

Maternal Health History (please circle and include date)



- Infections
- Previous miscarriage
- Exposure to tobacco/alcohol/drugs
- Fertility problems
- Medications while pregnant
- Gestational Diabetes
- Other: _____

FAMILY MEDICAL HISTORY

Please indicate family member and either Mother's side (M) or Father's side (F)

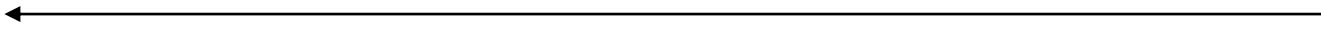
- Allergies
- Asthma
- Arthritis
- Autoimmune Disease
- Cancer
- Diabetes
- Heart Disease
- High Blood Pressure
- Kidney Disease
- Seizures
- Stroke
- Tuberculosis

Other _____

Environmental exposure to (pesticides, molds, dust, pets, ect.) ← _____

Activities (ie. swimming, video games, school/ day care, ect.) ← _____

DIET /FEEDING



Formula or Breastfed (How long?) _____

Food introduction – (age) _____ What food was given first, in what order and any reactions? _____

Do you have any Dietary restrictions? _____

Please describe the typical daily diet:

Morning Afternoon Evening

Please check if the following symptoms are currently a problem or are a recurring problem:

GENERAL

- | | | |
|----------------------------------------|---------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Chills | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Tremor | <input type="checkbox"/> Localized weakness |
| <input type="checkbox"/> Poor balance | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Bleed or bruise easily |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Strong thirst |

SKIN AND HAIR

- | | | |
|---------------------------------------------------------|-----------------------------------------------------------|----------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Moles |
| <input type="checkbox"/> Change in hair or skin texture | <input type="checkbox"/> Any other hair or skin problems? | |

HEAD, EYES, EARS, NOSE AND THROAT

- | | | |
|--------------------------------------|--------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Eye Glasses | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Poor vision |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Recurrent sore throat | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Facial pain | <input type="checkbox"/> Sores on lips or tongue | <input type="checkbox"/> Teeth problems |
| <input type="checkbox"/> Jaw clicks | <input type="checkbox"/> Headaches | |

CARDIOVASCULAR

- | | | |
|--------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold hands or feet |
| <input type="checkbox"/> Swelling of hands/feet | <input type="checkbox"/> Difficulty in breathing | |
| <input type="checkbox"/> Any other heart or blood vessel problems? | | |

RESPIRATORY

- | | | |
|--------------------------------------------------------------|---------------------------------------------------|-------------------------------------|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> wheezing |
| <input type="checkbox"/> Production of phlegm (what colour)? | <input type="checkbox"/> Any other lung problems? | |

GASTROINTESTINAL

- | | | |
|---------------------------------------------------|------------------------------------------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Black stool |
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas |
| <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Bad Breath |
| <input type="checkbox"/> Abdominal pain or cramps | <input type="checkbox"/> Any other problems with your stomach or intestines? | |



GENTOURINARY

- Pain on urination
- Sores on genitals
- Any other problems with the genital or urinary system?
- Blood in urine
- Bed wetting
- Urgency to urinate



MUSCULOSKELETAL

- Neck pain
- Back pain
- Hand/ wrist pain
- Muscle pain
- Muscle weakness
- Shoulder pain
- Knee pain
- Foot/ ankle pain
- Joint or bone problems



NEUROPSYCHOLOGICAL

- Seizures
- Concussion
- Have you ever been treated for emotional problems?
- Have you ever considered or attempted suicide?
- Any other neurological or psychological problems?
- Lack of coordination
- Quick temper / irritable
- Hyperactivity
- Learning Difficulties



COMMENTS

Please indicate any other problems you would like to discuss.
