Dr. Laura Pipher, ND
Infant & Toddler Intake form (0-3 years)

Date: _____

Name of Person Completing intake forms: _____

Relationship to child _____

Personal Information of Child

Full Name of child: _____

Date of birth _____ Age: _____ Sex: _____

Home address (Street, City, Province, Postal Code)

_____

With whom does the child live: _____

Does the child have siblings? Y/ N

If yes, how many? _____

Telephone (Primary – of parent/guardian): _____(Mobile/home/work)

Email address (of parent or guardian): _____

Emergency contacts:

Name: _____ Phone number: _____ Relation to child: _____

Name: _____ Phone number: _____ Relation to child: _____

Healthcare Team
Family Physician: _____ Phone: _____

Other healthcare providers:

Name/ Profession: _____ Phone: _____

Name/ Profession: _____ Phone: _____

Name/ Profession: _____ Phone: _____

What are your **current health concerns** for your child (please list in order of importance)?

1.	2.
3.	4.
5.	6

Immunizations

Please indicate which of the following immunizations your child has received:

- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ RV (rotavirus)
- ☐ DTaP* (diphtheria, tetanus, pertussis)
- ☐ PCV (pneuomococcal)
- ☐ IPV (Polio)
- ☐ Hib (Haemophilus influenza type b)
- ☐ Influenza (Flu vaccine)
- ☐ MMR (measles mumps rubella)
- ☐ Chicken pox (varicella)

Has your child ever experienced any adverse reactions to any vaccinations? Y / N

If YES, explain: _____

Prenatal Health

What was the age of the **Mother** at child's birth? _____ **Father?** _____

Was this the mother's first pregnancy? Y / N

Did the mother experience any of the following during pregnancy?

- ☐ High blood pressure
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Bleeding
- ☐ Nausea & vomiting
- ☐ Physical or emotional trauma

Did the mother use any of the following during pregnancy?

- ☐ Alcohol
- ☐ Tobacco- If no, was there any second hand exposure? _____
- ☐ Recreational Drugs : _____
- ☐ Over the counter drugs: _____
- ☐ Supplements: _____

Did the mother receive prenatal care during pregnancy? _____

How were the mother's stress levels during pregnancy? LOW MODERATE HIGH

If **moderate or high,** what were the main sources of stress? _____

What cravings did the mother have during pregnancy? _____

Birth History

Term length (circle one): Full Term Premature: _____ weeks Late _____ weeks

Length of Labour _____ Weight at birth: _____ Length at birth: _____

Please check **Any of the following** that apply to the child's birth:

- ☐ Induced
- ☐ Vaginal birth
- ☐ C section
- ☐ Forceps used
- ☐ Anesthesia (epidural) used

Were there any complications? Y / N

If YES, Explain:
_____

Did the child experience **any of the following** at or shortly after birth?

- ☐ Jaundice
- ☐ Rashes
- ☐ Seizures
- ☐ Birth injuries
- ☐ Birth defects: Explain _____
- ☐ Other: _____

Is the child **currently experiencing** any of the above conditions? Y / N

If YES, explain: _____

Diet

Is your infant currently breastfeeding? Y / N

If NO:

Was your infant breastfed? Y / N For How long? _____

Formula Name: _____ Milk / Soy / Other _____

Which Foods Have Been Introduced:
Before six months (include approximate month)

_____

_____

_____

After six months (include approximate month)

_____

_____

_____

_____

Does your child have any food allergies or intolerances? Y / N

If YES, Explain:

_____

_____

_____

Does your child have any dietary restrictions? Y / N

If YES, explain:

_____

_____

If your child is eating solid foods, describe a typical day's diet

Breakfast: _____

Lunch _____

Dinner: _____

Snacks: _____

Beverages: _____

Health and Development

Did your child experience any significant illness in the first year? Y / N

If YES, explain: _____

At what age did your child first:

Sit up _____ Crawl _____ Walk_____ Talk _____ First tooth _____

Describe your child's **sleep pattern:**

_____

_____

Describe your child's **temperament:**

_____

_____

Does your child attend daycare? Y / N Does your child attend school? Y / N

If YES, where & how often? _____

If YES, how is your child's **performance & behaviour** at daycare/ school?

_____

_____

What are your child's favourite activities? _____

Is your child taking any **vitamins, herbs, supplements, or other over the counter products?** Y / N

Explain: _____

Does your child take any **prescription medication?** Y / N

Explain: _____

Please list any **allergies** & note their severity

_____

Has your child been **diagnosed** with any significant illnesses or conditions? Y / N
Please explain:

_____

Family health history

Please check the **YES** box beside any conditions affecting **family members**, and indicate who (F- father, M-mother, G-Grandparent, S- sibling). Please circle whether the condition is **Past or Current**

Condition	**YES**		**Relation**	**Condition**	**YES**		**Relation**
Asthma		Past Current	M F G S	High blood pressure		Past Current	M F G S
Allergies		Past Current	M F G S	Heart disease		Past Current	M F G S
Anemia		Past Current	M F G S	Hepatitis		Past Current	M F G S
Arthritis		Past Current	M F G S	Headaches		Past Current	M F G S
Cancer		Past Current	M F G S	Kidney Disease		Past Current	M F G S
Diabetes		Past Current	M F G S	Stroke		Past Current	M F G S
Eczema		Past Current	M F G S	Tuberculosis		Past Current	M F G S
Epilepsy		Past Current	M F G S	Osteoporosis		Past Current	M F G S
Mental illness		Past Current	M F G S	Addiction		Past Current	M F G S

Autoimmune		Past Current	M F G S	Other:		Past Current	M F G S

Environment

Does your child have any electronics? Describe _____

Does anyone in the child's household smoke? Y / N

How would you describe the **current emotional climate** of the home?

_____

Are there any pets in the house? Y / N _____

Anything else?

_____

_____