Point Grey Wellness Clinic

Dr. Irene Karatzas ND
4383 W.10th Avenue, Vancouver, B.C. V6R 2H6
Tel# (604)222-1044
Fax: (604)222-1055
www.pointgreywellness.com

Pediatric Initial Intake Form

Welcome to our clinic. Please complete this confidential intake form so that we may help you achieve your optimal level of health. Thank you!

Date ______________

☐ Female
☐ Male ____ Birth Date (Month/Day/Year) ___________ AGE __
First Name Middle Name Last Name

NAME AND RELATIONSHIP OF PERSON LEGALLY RESPONSIBLE (Parent, Guardian)______________________________

HOMEADDRESS ____
Street City / Province Postal Code

HOME PHONE ________________ BUSINESS PHONE ________________ OCCUPATION ________________

NAME OF SPOUSE ______________________________ # OF CHILDREN AND AGES ____________________

NEAREST RELATIVE OR NEXT OF KIN ____
Name Relationship

REFERRED BY ______________________________ E- MAIL ADDRESS: ____________________________

CARECARD NUMBER ____________________________ FAMILY M.D. ______________________________

CURRENT HEALTH CONCERN(S): When did concerns(s) begin (be specific)?

1. ____
2. ____
3. ____
4. ____

Are you under the care of another physician or practitioner (ND, DC?) ______________________________

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
☐ Skin conditions ☐ Bronchitis ☐ 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, ect.) ________________________________

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) ______________________

Activities (ie. swimming, 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?** ______________________

____

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

☐ Poor appetite ☐ Poor sleep ☐ Fatigue
☐ Fevers ☐ Chills ☐ Night sweats
☐ Sweat easily ☐ Tremor ☐ Poor balance

SKIN AND HAIR

☐ Rashes ☐ Ulcerations ☐ Hives
☐ Itching ☐ Eczema ☐ Pimples

☐ Dandruff ☐ Loss of hair ☐ Moles

HEAD, EYES, EARS, NOSE AND THROAT

☐ Headaches ☐ Poor vision ☐ Grinding teeth
☐ Earaches ☐ Poor hearing ☐ Sinus problems
☐ Nosebleeds ☐ Recurrent sore throat ☐ Sores on lips

CARDIOVASCULAR

☐ High/low blood pressure ☐ Low blood pressure ☐ Chest pain
☐ Irregular heartbeat ☐ Fainting ☐ Cold hands/feet
☐ Swelling of hands/feet ☐ Difficulty in breathing

RESPIRATORY

☐ Cough ☐ Coughing blood ☐ Bronchitis
☐ Pneumonia ☐ Shortness of Breath ☐ wheezing
☐ Production of phlegm (what colour)? ☐ Any other lung problems?

GASTROINTESTINAL

☐ Nausea/vomiting ☐ Indigestion ☐ Black stool
☐ Blood in stool ☐ Constipation ☐ Gas
☐ Rectal pain ☐ Diarrhea ☐ Bad Breath
☐ Abdominal pain or cramps ☐ Any other problems with your stomach or intestines?

GENITOURINARY

☐ Pain on urination ☐ Blood in urine ☐ Urgency to urinate
☐ Sores on genitals ☐ Bed wetting

MUSCULOSKELETAL

☐ Neck/back pain ☐ Muscle pain/weakness ☐ Foot/ ankle pain
☐ Hand/ wrist pain ☐ Shoulder pain ☐ Joint problems

NEUROPSYCHOLOGICAL

☐ Seizures ☐ Lack of coordination ☐ Hyperactivity
☐ Concussion ☐ Quick temper / irritable ☐ Learning Difficulties

COMMENTS: Please indicate any other concerns you would like to discuss.

____
____
____
____
____
____
____
____
____