ASPIRE MEDICINE

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Targeted Treatments.
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Pediatric Intake Form

Patient Information:

Patient's Full Name:______________________ Preferred Name:______________________

Date of Birth:______________________ Sex (M/F/other):______________________

Grade of School:______________________ Street Address:______________________

City:______________________ Prov:______________________ Postal Code:______________________

Email:______________________ Phone Number:______________________

How did you hear about our clinic?______________________

Guardian Information:

Mother's Name and Occupation:______________________

Father's Name and Occupation:______________________

Parents are (Select): Married Separated Divorced Living Together Other

Is the child currently under a custody agreement, if so, please explain:

____

REASON FOR OFFICE VISIT: Please list in order of importance

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

Phone 403.347.4002 • **Fax** 403.347.4022 • **Email** info@aspiremedicine.ca
2810 Bremner Ave Unit 120, Red Deer, AB T4R 1M9

Medical History:

Regular Family Physician and/or Pediatrician:________________________

Any previous blood work? If so, when:_____________________

List any Current / Past Diagnoses, Surgeries & Hospitalizations, including date occurred:

1. ____________________________________ 4. ____________________________________
2. ____________________________________ 5. ____________________________________
3. ____________________________________ 6. ____________________________________

Any reactions to past vaccinations:____

Family History:

Please check (✓) if any of the family members below have been diagnosed (at any time) with any of the following conditions:

	Autoimmune	Diabetes Mellitus	Obesity	Mental Illness	Cardiovascular Disease	Celiac	Cancer	Allergies / Asthma	Other
Mother									
Father									
Maternal Grandmother									
Maternal Grandfather									
Paternal Grandmother									
Paternal Grandfather									
Sibling(s)									

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Medications / Supplements:

Please list all medications & dosages of any over the counter or prescription medication your child is currently taking:

Please list all supplements, including their dosage, your child is currently taking:

Allergies:

Please list any known allergies to foods, drugs, environment, or animals:

Please list any suspected allergies to foods, drugs, environment, or animals:

Birth / Developmental History:

Mother's Pregnancy History:

Age at conception:________ Did she have other children already? Yes No

Diabetes: Yes No Coffee: Yes No Nausea/Vomiting: Yes No

Smoking/Recreational Drugs: Yes No Emotional Stress: Yes No

Preeclampsia: Yes No Other :________

Labour/Delivery:

Length of labor:________

Premature: Yes No Vaginal Birth: Yes No Traumatic Birth: Yes No

NICU: Yes No Other :________

Health of baby at birth:________

Development / Milestones:

Any diagnosed learning or behavioural disorders:________

Lifestyle:

Does the child have any learning, behavioural or developmental concerns:

___

Any major household stressors child has witnessed or gone through:

___

Any significant environmental exposures (ie: mold, living near refinery, known toxin / chemical /pesticide exposures):

___

Does anyone in the home (or any additional caregivers) smoke:

___

Does your child get in daily physical activity? If so, what kinds & how long?

___

Any sleep issues (i.e.: difficulties falling asleep, difficulties staying asleep, nightmares, night terrors, sleep walking, etc…)

___

Diet / Nutrition:

Child breastfed: Yes No For how long:____________

Formula fed: Yes No When:____________

When was the child started on solid foods:____________

Any reactions with food introductions? Yes No

Does your child have any dietary restrictions (i.e.: gluten free, vegan):____________

Do you consider your child a “picky” or “selective” eater? Yes No

Thank you for the information – we look forward to meeting with you!

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