Dr. Susan Hamilton

Discover the healing power within you

PEDIATRIC / ADOLESCENT INTAKE

Today's date______________________

First name: _________________ _________________ __________ M ____ F______
(Last name) (First name) (Middle Initial)

Preferred name: ___________________ Age: _____ Date of Birth: ____________

Address: ____
(Street #/PO Box) (City) (Prov.) (Postal Code)

Please list only the numbers at which we may contact you.

Parent's Name: ____

E-Mail: ____________________________ Cell Phone: ______________________

Home phone: _______________________ Work: _________________ Ext: ______

What is the **best way** to communicate with you between office visits? (E-mail, Home, Work, Cell Phone). Is there any place you do **NOT** want me to leave a message? ______________________

Please be aware that e-mail is not a secure communication and that discussion of your medical care will become part of your medical record.

May Dr. Hamilton send you educational/promotional materials such as newsletters via e-mail? ___ Yes ___ No

May Dr. Hamilton discuss your private medical information with you via e-mail? ___ Yes ___ No

How did you hear about our clinic? _______________________________________

PLEASE LIST THE MOST IMPORTANT HEALTH CONCERNS / PROBLEMS:

MEDICATIONS:	Now	past	frequency	SUPPLEMENTS:	now	past	dosage
Aspirin	___	___	________	Vitamins	___	___	______
Tylenol	___	___	________	Fluoride	___	___	______
Antibiotics	___	___	________	Herbs	___	___	______
Decongestants	___	___	________	Homeopathics	___	___	______
Other________	___	___	________	Other________	___	___	______

Allergies to drugs or medications: _______________________________________

CHILDHOOD ILLNESSES:

__ Chicken Pox	__ Scarlet Fever	__ Mononucleosis	__ Mumps
__ Measles	__ Rheumatic Fever	__ Ear Infections	__ Tonsillitis
__ Rubella	__ Strep Throat	__ Pneumonia	__ Other ________________________

IMMUNIZATIONS: (list types, dates given and any adverse reactions)

PRENATAL / BIRTH / FEEDING HISTORY:

How was the mother's health during the pregnancy? (check, then describe below)

___ Age ___ Trauma/injury ___ Alcohol consumption ___ Medications
___ Bleeding ___ Stress ___ Drugs ___ Smoking
___ Nausea ___ Illness ___ High Blood Pressure ___ X-Rays
___ Toxemia ___ Other

Term: Full_____ Premature ______ Late _________ Birth weight ___________

How were the pregnancy / birth? Easy _______ Difficult ________

Place of birth: Hospital _____ Home ______ Clinic ______ Other____________

Feeding: Breast fed ___ How long? _____ Cow's Milk? ___________
Formula fed ___How long? _______ Type of formula _______________________
Age solid food began ______What foods? ________________________________
Food allergy/intolerance ____
Favourite foods ____

Sample daily diet: (choose a typical day & include food and liquids)

SOCIAL HISTORY:

Parents: Married _____ Common Law _____ Separated_____ Divorced______
Mother's occupation________________ Full time ______ Part time_____
Father's occupation ________________ Full time ______ Part time_____

Other Guardian: _____________________________ Relationship ____________________

Others residing in the home____________________ Relationship _____________________

Daycare/ Preschool/ School____________________ Where? ________________________

Full time___ Part time ___ how many hours per day? _____ days per week? ______

Siblings:

Name	Age	Health Concerns

Interaction with relatives: Who? ______________ How often? _____________________

Do you have any other health concerns you would like to discuss?