

**PEDIATRIC (2- 12 YEARS) INTAKE QUESTIONNAIRE**

**GENERAL INFORMATION:**

1.) What is the purpose of your visit...what can I do that would help your child the most?  
 \_\_\_\_\_  
 \_\_\_\_\_

2.) Please observe your child and provide general answers to the following. Please circle your answer:  
 In general, are your child's eyes normally bright Y/N? Is he/she alert and focused or easily agitated? Irritable? Are there dark circles under his/her eyes (not due to lack of sleep)? Y/N? Is the skin plump and smooth or dry, scaly? Are there any rashes, inflammatory issues of the skin, cracks, etc.? If you have any other comments, please list below:  
 \_\_\_\_\_  
 \_\_\_\_\_

3.) Has your child been "diagnosed" with a medical or psychological condition by a specialist, medical doctor, or other doctor?  
 \_\_\_\_\_

4.) If you answered yes above, what is his/her prognosis? \_\_\_\_\_

5.) How often does he/she go to the specialist(s)? \_\_\_\_\_

*Please list specialists, doctors, other contact information (including phone #'s) on a separate page, if required.*

6.) If you have you tried any of the following, please list below. Be as specific as possible:

	Date started	Date stopped	Recommended by	Reaction – positive/negative/no difference...give details
<b>SUPPLEMENTS</b>				
<b>MEDICATIONS</b>				
<b>DIET CHANGES</b>				
<b>OTHER?</b>				

**HISTORY:**

7.) Immunizations (note below, or attach copy of immunization record):

VACCINE	AGE	REACTIONS

8.) Mother: did you have any immunizations as a teenager, young adult, pregnant or nursing mother? If yes, please list:  
 \_\_\_\_\_

9.) List any complications during pregnancy, delivery or early weeks of your child's life that concerned you or your doctor:  
 \_\_\_\_\_

Gestational age at birth: \_\_\_\_\_

10.) How many ultra-sounds did you have? \_\_\_\_\_ Did you ever take fertility drugs or CLOMID? \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Today's Date: \_\_\_\_\_

- 11.) Did you breastfeed? \_\_\_\_\_ For how long? \_\_\_\_\_ What did you give your child **after** or **along with** the breastmilk? \_\_\_\_\_  
\_\_\_\_\_
- 12.) How did he/she react to the breastmilk? \_\_\_\_\_, formula? \_\_\_\_\_, cow's milk? \_\_\_\_\_
- 13.) At which age, and in what order did you introduce solid foods? Provide as many details as you can remember:  
\_\_\_\_\_  
\_\_\_\_\_
- 14.) Did your child suffer from colic? \_\_\_\_\_ Coping methods: \_\_\_\_\_
- 15.) Please circle if any of the following apply... list others if applicable:  
**Family History of:** Multiple Sclerosis, Type I diabetes, Lupus, Rheumatoid Arthritis, Crohn's Disease, AIDS, Fibromyalgia or Chronic Fatigue Syndrome, neurological problems, mental illness, heart disease, cancer, allergies, diabetes, intestinal diseases or problems. Comments: \_\_\_\_\_  
\_\_\_\_\_
- 16.) **Family history of learning disorders**, (ADD/ADHD, ASD, PDD, Dyslexia, Down's Syndrome, Schizophrenia)? \_\_\_\_\_
- 17.) Has your child had any **ear** infections? \_\_\_\_\_ List how many & age? \_\_\_\_\_
- 18.) Was the treatment (for ear infections) the same each time, and how did he/she react?  
\_\_\_\_\_  
\_\_\_\_\_
- 19.) Has your child had, or do they presently have any infections or illnesses? \_\_\_\_\_
- 20.) If your child has a re-curing infection of the same type, list social or dietary factors that seem to occur at the same time:  
\_\_\_\_\_

### **DIET & DIGESTION:**

Please fill out a DIET DAIRY for 7 days. Record what/how much your child eats & drinks, comments, reactions & moods.  
**Pay particular attention to your child's reactions to foods (behavior, bowel habits, etc.) while doing this diet diary.**

- 21.) **Are there any known food allergies or intolerances?** \_\_\_\_\_
- 22.) Describe your child's appetite: \_\_\_\_\_ Number of meals/snacks per day: \_\_\_\_\_
- 23.) Does your child have favourite foods? \_\_\_\_\_ How often does he/she eat them? \_\_\_\_\_
- 24.) Does your child have cravings? \_\_\_\_\_ If yes, which foods? When is the food consumed? \_\_\_\_\_
- 25.) Are there foods your child absolutely refuses to eat? \_\_\_\_\_
- 26.) Are you concerned about your child eating too much? Too little? Developing poor eating habits? Circle if applicable.
- 27.) **Please circle the following if they apply:** Difficulties digesting any foods – pain, cramping, screaming, headaches, gas, bad breath, diarrhea, constipation? Does he/she experience: Alternating diarrhea/constipation, straining to move bowels? Are any of the above situations related to **particular foods or circumstances** (such as emotional upset, etc?)  
\_\_\_\_\_  
\_\_\_\_\_
- 28.) Stools – formed, colour? \_\_\_\_\_, foul-smelling, frothy or floating/greasy? Are there pieces of undigested food? \_\_\_\_\_  
Other comments relating to bowel movements: \_\_\_\_\_ Number BM/day: \_\_\_\_\_
- 29.) Is your child toilet-trained? \_\_\_\_\_ Does he/she have accidents? \_\_\_\_\_ Bed-wetting? \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**DEVELOPMENTAL ASPECTS:**

- 30.) At what age did your child begin to speak? \_\_\_\_\_ point? \_\_\_\_\_
- 31.) Did you notice that your child began to **regress** in any of the above, or in other areas, and if so at what age? \_\_\_\_\_
- 32.) How long is your child's attention span (approximately)? \_\_\_\_\_
- 33.) Does your child sleep through the night? \_\_\_\_\_ Is he/she well/rested? \_\_\_\_\_
- 34.) Comments from teachers, behavioural therapists, on your child's progress since diagnosis: \_\_\_\_\_  
Is your child: aggressive? \_\_\_\_\_ Intolerant to heat &/or sunlight? \_\_\_\_\_  
Is your child stressed? \_\_\_\_\_ Does he/she participate in sports/play groups? \_\_\_\_\_  
What does he/she like to do for fun? \_\_\_\_\_ Is he/she happy? \_\_\_\_\_  
How much exercise does your child get? \_\_\_\_\_ Hours spent watching T.V./video games/day \_\_\_\_\_
- 35.) How does your child interact in a group environment...with children? \_\_\_\_\_  
...with other adults? \_\_\_\_\_
- 36.) Is your child generally happy?  
\_\_\_\_\_  
\_\_\_\_\_
- 37.) Please list any additional comments, concerns or questions that you may have:

**ATTACH A SEPARATE SHEET (IF REQUIRED) TO INCLUDE ANY OTHER INFORMATION THAT MAY BE RELEVANT**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Your name: \_\_\_\_\_ Address: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Contact information: Daytime: \_\_\_\_\_ Evening: \_\_\_\_\_ E-mail: \_\_\_\_\_

Disclaimer: Please note that your personal information will be kept strictly confidential. Please see our privacy policy for further details at: [www.wellnesswizards.net](http://www.wellnesswizards.net). The information and recommendations which you will receive from Wellness Wizards is meant for procuring and attaining health and well-being for your child and not to diagnose, treat or cure any condition. If your child has a serious medical condition, please see your medical health professional.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FAX completed forms to: 905-257-3979 or  
MAIL to: Wellness Wizards Limited, P.O. Box 478 Dundas St. West, Oakville, ON. L6Y 6Y0**

**PLEASE NOTE:**

We cannot guarantee that our office is 100% nut-free.  
Please notify us ahead of time if you have any severe or life-threatening allergies.  
We will do our best to accommodate your needs. Please call us at: 416-948-9355 if you have any questions.  
Thank you for choosing Wellness Wizards.

