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:

<table>
<thead>
<tr>
<th>SUPPLEMENTS</th>
<th>Date started</th>
<th>Date stopped</th>
<th>Recommended by</th>
<th>Reaction – positive/negative/no difference…give details</th>
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<th>MEDICATIONS</th>
<th>Date started</th>
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<th>Recommended by</th>
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<th>DIET CHANGES</th>
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<th>Recommended by</th>
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<th>OTHER?</th>
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<th>Date stopped</th>
<th>Recommended by</th>
<th>Reaction – positive/negative/no difference…give details</th>
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HISTORY:

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

<table>
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<tr>
<th>VACCINE</th>
<th>AGE</th>
<th>REACTIONS</th>
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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?

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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?___________________________
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:________________________
________________________________________________________________________________________________

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<th>Is your child: aggressive?</th>
<th>Intolerant to heat &amp;/or sunlight?</th>
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<tr>
<td>Is your child stressed?</td>
<td>Does he/she participate in sports/play groups?</td>
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<tr>
<td>What does he/she like to do for fun?</td>
<td>Is he/she happy?</td>
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<tr>
<td>How much exercise does your child get?</td>
<td>Hours spent watching T.V./video games/day</td>
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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.