



Dr. Tamzin Morley, ND

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Health History Intake Form - PEDIATRIC:

Care Card # (PHN): _____ Date: _____

First Name: _____ Last Name: _____

Gender: _____ Date of Birth (DD/MM/YY): _____ Age: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Caregiver Name:		
Home phone:		
Work phone		
Cell phone:		
Email Address:		
If needed, can the clinic contact you via email (circle): YES NO		

Emergency contact Name: _____ Phone: _____

Relationship: _____

How did you hear about Dr. Tamzin Morley: _____

Health Concerns:

1. _____
2. _____
3. _____
4. _____
5. _____

Medications (Prescription and Non-Prescription): _____

Allergies (Medication, Food, Environmental): _____

Supplements (Vitamins, Minerals, Herbs, etc): _____

Past Procedures/Surgeries/Hospitalizations: (Description & Date): _____

Past Medical History (P=Past, C=Current):

Condition	P	C	Condition	P	C	Condition	P	C
Acne			Fatigue			Scarlet Fever		
Allergies			Frequent Colds and Flu			Skin Disease		
Anemia			Headache			Sinusitis		
Bed wetting			Heart murmur			Strep Throat		
Birth defects			High Fever			Stuffy nose		
Cancer			Hyperactivity			Thrush		
Chicken Pox			Insomnia			Tonsilitis		
Colic			Jaundice					
Cold Sores			Learning Disorder			Tuberculosis		
Constipation			Low/High BP			Typhoid Fever		
Cough/wheezing			Malaria			Vomiting spells		
Cradle Cap			Mononucleosis			Warts		
Depression			Moodiness			Whooping Cough		
Diarrhea			Mumps			Worms		
Dizzy Spells			Parasites			Other:		
Earaches/Infections			Pneumonia					
Exposure to cigarette smoke			Rheumatic Fever					
Epilepsy/seizures			Rubella					

Immunization	Age given	Any Adverse Reactions?
DPT (Diphtheria, Pertussis, Tetanus)		
MMR (Measles, Mumps, Rubella)		
Polio		
Haemophilus Influenza Type B (Meningitis)		
Hep-B (Hepatitis B)		

Family Medical History (Blood Relatives, NOT including your child):

	Which Relative and Age of Onset?	Doctors notes
<input type="checkbox"/> Addiction		
<input type="checkbox"/> Arthritis		
<input type="checkbox"/> Allergies/Asthma		
<input type="checkbox"/> Cancer		
<input type="checkbox"/> Depression/Anxiety		
<input type="checkbox"/> Diabetes		
<input type="checkbox"/> Hepatitis		
<input type="checkbox"/> High Blood Pressure		
<input type="checkbox"/> High Cholesterol		

<input type="checkbox"/> Kidney Disease		
<input type="checkbox"/> Obesity		
<input type="checkbox"/> Osteoporosis		
<input type="checkbox"/> Seizure/Epilepsy		
<input type="checkbox"/> Thyroid Disease		

Lifestyle and Social History:

Parents/Caregivers:	Single	Married	Separated	Divorced	Doctor's notes
Mother/Caregiver occupation:					
Father/Caregiver occupation:					
# of Siblings					
Daycare/Preschool:	Hrs per day?:	Hrs per week?:			
Regular Exercise?:	Type?:				

Social	Yes	No	Details	Doctor's notes
Interacts well with others?				
Good social network?			Who?	

Lifestyle:	Yes	No	Details
Does your child feel stressed?			Level (circle): Low Medium High
Source of stress?			
What does your child do to relieve stress?:			

Sleep:	Yes	No	Details
Problems falling asleep?			
Problems staying asleep?			
Wake up feeling rested?			# hours sleep per night?:
Does your child dream?			

Diet	Details
Does your child follow a particular diet?	
Known food allergies/intolerances?	
What is your child's typical breakfast?	
What is your child's typical lunch?	
What is your child's typical dinner?	
How much water does your child drink per day?	
What is your child's current weight?	
What was your child's weight one year ago?	
What is your child's height?	

Prenatal/Birth/Feeding History:

Mothers health during pregnancy:		Doctor's notes
Age:	Medications:	
Bleeding:	X-Rays:	
Nausea:	Smoking:	
Stress:	Alcohol consumption:	
Trauma/Injury:	Recreational drug use:	
High Blood Pressure:	Other:	
Term: Preterm:_____ Full term :_____ Birth Weight:_____		
Pregnancy/Labour and Delivery: Easy: _____ Difficult:_____ Vaginal:_____ C-Section:_____		
Feeding of infant: Breast fed:_____ how long?:_____		
Formula fed:_____ how long?: _____ Type of formula: _____		
Age solid food was introduced:		
Any cow's milk introduced:		