#480 – 309 2nd ave W
PRINCE RUPERT, B.C., V8J 3T1
PH. 250-624-4255
FAX. 1-855-743-4254
EMAIL. INFO@GREATBEARCLINIC.COM
WWW.GREATBEARCLINIC.COM

Pediatric Intake Form Date (month/day/year): ________________

CONFIDENTIAL: All information remains confidential and is released only with your written permission. The information you provide acts to serve the doctors at Great Bear Natural Medicine Clinic in their ability to assess and treat you appropriately based on your concerns.

Please completely fill out form prior to the initial visit. If extra room is needed, please provide on separate sheet and attach. Arrive at least 10 minutes early to the first visit to complete a consent form.

Last name: ____________________ First name: _______________________ Name preference: _________________
Birthday (month/day/year): __________________________ Age: _______________________
Birthplace: __________________________
Health card number (required): __________________________
Gender / self-identity: __________________________
Race (ancestral heritage): __________________________
Lives with: _________________________ Guardian(s)/Parent(s) names: ____
Street address: ____ City: __________________________ Postal code: ______________
Cell phone (mother/father/other): __________________________ Home phone: __________________________
Guardian/Parent email address: ____

Insurance:
Provincial care card number: __________________________ Province of care card registration: ____________________
Insurance company: __________________________________ Group plan #: ___________________ Policy #: ________________

_________ I consent to discussing my child's case through electronic means, such as email, if necessary. This may include case information, updates or sending/receiving lab results. I can revoke this consent at any time.

Person to notify in case of emergency:
Name: _________________________ Relation: ________________ Phone number: ____________________

Where and when did the child last receive medical care and what was the reason?
____

Medical doctor: ________________________ Clinic Name:____
Clinic Address: ____ Clinic Phone: ____________________________
Other medical/health service(s) used: ____
Date of last physical exam: __________________________________

How did you hear about the Great Bear Natural Medicine Clinic? ____

When was your child last really healthy? ____

Please list all primary diagnoses the child has had in their lifetime.

Please describe the child's reason for this visit and their most important symptoms.

Family Medical History (blood relatives) – Check those that apply and indicate who had this

- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Heart problems
- ☐ Kidney problems
- ☐ Cancer
- ☐ Eczema
- ☐ Autism
- ☐ Behavioural problems
- ☐ Epilepsy
- ☐ Nervous breakdown
- ☐ Asthma
- ☐ Food allergies
- ☐ Hives or hay fever
- ☐ Developmental delay
- ☐ Thyroid problems
- ☐ Bleeding problems
- ☐ Weight problems
- ☐ Other:

Surgeries and hospitalizations

Has the child had removed: When?

- ☐ Tonsils ______________
- ☐ Appendix ______________
- ☐ Tubes in ears ______________

List any other operations or periods of hospitalization for any illness:

- ☐ ____
- ☐ ____
- ☐ ____

Allergies - Is the child allergic to any?

- ☐ Food:
- ☐ Drugs or medications:
- ☐ Other substances:

Any history of anaphylaxis? YES / NO

Current Medications - Does the child regularly use:

- ☐ Laxatives
- ☐ Tylenol or Ibuprofen
- ☐ Antacids
- ☐ Sleeping aids
- ☐ Corticosteroids/Topical steroids
- ☐ Asthma inhaler(s)
- ☐ Anti-histamines
- ☐ Digestive enzymes
- ☐ Other:

Please list any other medications, supplements, minerals and vitamins the child is currently taking:

Immunizations

Has the child been given:

- ☐ Polio
- ☐ Diphtheria/Tetanus/Pertussis (DPT)
- ☐ Measles/Mumps/Rubella (MMR)
- ☐ Rotavirus
- ☐ Hepatitis B
- ☐ Hepatitis A
- ☐ Haemophilus influenzae type b (Hib)
- ☐ Pneumococcal
- ☐ Meningococcal
- ☐ Influenza
- ☐ Varicella (chicken pox)
- ☐ HPV
- ☐ COVID
- ☐ Adverse reaction(s):

Mother's health during pregnancy:

Infections:	______________	Trauma/injury:	______________	Alcohol use:	______________
Bleeding:	______________	Stress:	______________	Drug use:	______________
Nausea:	______________	High blood pressure:	______________	Smoking:	______________
Illness:	______________	Toxemia:	______________	X-rays:	______________

Age during pregnancy: ________________

Medications during pregnancy: ____________________ Vaccinations during pregnancy: ________________________

Number of ultrasounds during pregnancy and at what weeks (if applicable): ____

Work during pregnancy? (Yes / No) If yes, what type of work and until what week?______________________________

Complications?:____

How was pregnancy for the mother? (mood, stress, etc.): ____

Delivery details:

Number of weeks at delivery: _______________ Weight of baby at delivery: ________________

Type of delivery (circle all that may apply): vaginal / C-section / forceps / vacuum / hospital / home / water

Medications during delivery (circle all that may apply): epidural / antibiotics / induction / none / other: ________________

Interventions during/following delivery:____

Complications?:____

Dietary Intake - past 24 hours (usual pattern) of meals, snacks, beverages and water