



# Nicky Gonis Holistic Health

## PAEDIATRIC INTAKE FORM

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/guardian name/s: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Name of GP: \_\_\_\_\_ Suburb: \_\_\_\_\_

Name of Specialist: \_\_\_\_\_ Suburb: \_\_\_\_\_

Specific reason for your appointment and other current health concerns:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Recent pathology/tests/investigations/operations etc, please provide dates and outcomes:

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

Current medications (including dosage):

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

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Nicky Gonis Holistic Health  
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Current supplements (dose and brand):

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Please list any health concerns of family members including siblings, parents and grandparents:

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Please list any previous medical history:

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Please explain your child's general temperament:

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Has your child taken any antibiotics? If yes, when and how many courses?

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Did you experience any pregnancy complications?

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- What was your child's birth weight? \_\_\_\_\_
- Was your child breastfed? Exclusively? \_\_\_\_\_ How long? \_\_\_\_\_
- Was your child formula fed? Which formula? \_\_\_\_\_
- Birth details: (please tick all that applies)
  - Vaginal delivery
  - Caesarean section
  - Induced labour
  - Forceps delivery
  - Vacuum extraction
  - Fetal distress
  - Low birth weight
  - Premature delivery
  - Pain relief, please specify: \_\_\_\_\_
  - Anesthesia used, please specify: \_\_\_\_\_
  - Epidural given
  - Neonatal Intensive Care, please provide details: \_\_\_\_\_
  - Hospitalization in the first year, please provide details: \_\_\_\_\_

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## Early development:

What age were solids introduced? \_\_\_\_\_

What age was your child toilet trained? \_\_\_\_\_

Were milestones achieved on time? \_\_\_\_\_

## General Health Questionnaire:

Below are a series of health symptoms. Please check boxes with a tick for present symptoms

Please leave the box blank if your child has never experienced this symptom.

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Bloating            | <input type="checkbox"/> Constipation             | <input type="checkbox"/> Diarrhea             | <input type="checkbox"/> Flatulence        |
| <input type="checkbox"/> Fussy eating        | <input type="checkbox"/> Nausea                   | <input type="checkbox"/> Reflux               | <input type="checkbox"/> Colic             |
| <input type="checkbox"/> Irregular Bowels    | <input type="checkbox"/> Poor appetite            | <input type="checkbox"/> Burping              | <input type="checkbox"/> Fatigue           |
| <input type="checkbox"/> Bedwetting          | <input type="checkbox"/> Sleeping problems        | <input type="checkbox"/> Anxiety              | <input type="checkbox"/> Hearing problems  |
| <input type="checkbox"/> Poor concentration. | <input type="checkbox"/> Behaviour issues         | <input type="checkbox"/> Mood swings          | <input type="checkbox"/> Learning issues   |
| <input type="checkbox"/> Autism              | <input type="checkbox"/> Hyperactivity/ADHD       | <input type="checkbox"/> Developmental delays | <input type="checkbox"/> Speech problems   |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Hay fever                | <input type="checkbox"/> Asthma               | <input type="checkbox"/> Diabetes          |
| <input type="checkbox"/> Eczema/Psoriasis    | <input type="checkbox"/> Skin rashes              | <input type="checkbox"/> Sinus problems       | <input type="checkbox"/> Heart trouble     |
| <input type="checkbox"/> Respiratory issues  | <input type="checkbox"/> Recurrent antibiotic use | <input type="checkbox"/> Ear infections       | <input type="checkbox"/> Throat infections |
| <input type="checkbox"/> Poor wound healing  | <input type="checkbox"/> Fractures/broken bones   | <input type="checkbox"/> Growing pains        | <input type="checkbox"/> Seizures          |

Allergies, please specify:

\_\_\_\_\_

Recurrent colds/infections, please explain:

\_\_\_\_\_

Food intolerances, please list:

\_\_\_\_\_

Any other health concerns:

\_\_\_\_\_

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Do the following pertain to your household?

- Smoking
  Old home
  Renovations
  Pets

Vaccination history:

Is your child currently up to date with their vaccines? Please circle: YES NO

Please place a tick for yes or a cross for no next to each vaccination (Please list any others in the space provided)

Hepatitis B ( <u>HepB</u> )	Haemophilus B (Hib)	Measles, mumps, rubella (MMR)	Meningococcal ACWY
Rotavirus – ORAL (RV1, RV5)	Pneumococcal (PCV13)	Varicella – Chicken pox (VAR)	Meningococcal B ( <u>MenB</u> )
Diphtheria, tetanus acellular pertussis/Whooping cough ( <u>DtaP</u> )	Inactivated Poliovirus (IPV)	Hepatitis A ( <u>HepA</u> )	
Influenza (IIV)	Human Papillomavirus (HPV)		

Did your child experience any adverse reactions to the following vaccines given? Please circle: YES NO

If yes, please provide details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is your child involved in any extracurricular activities, such as sports or music lessons? If so, what are they and how often?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please understand that all information is held in strict confidentiality. It is very important that you as a client builds a strong sense of trust with me, the practitioner. If there is anything further you would like to discuss with me before the session or any boundaries that you would like to set to ensure your comfort and relaxation, please bring these issues to my attention.

Thank you for completing the intake form  
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