

Nicky Gonis Holistic Health

PAEDIATRIC INTAKE FORM

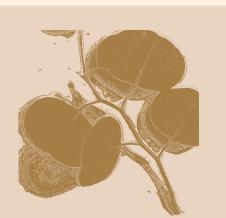
Name:	DOB:		
Parent/guardian name/s:			
Address:			
	Email:		
Height:	Weight:		
Name of GP:	Suburb:		
Name of Specialist:	Suburb:		
Specific reason for your app	pointment and other current health concerns:		
1			
2			
3			
	estigations/operations etc, please provide dates and outcomes:		
Current medications (includi	ing dosage):		
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Current supplements (dose and	d brand):
Please list any health concerns	of family members including siblings, parents and grandparents:
Please list any previous medica	al history:
Please explain your child's gen	eral temperament:
Has your child taken any antibio	otics? If yes, when and how many courses?
Did you experience any pregna	ncy complications?
What was your child's birth	n weight?
	Exclusively?How long?
Was your child formula fed	I? Which formula?
Birth details: (please tick al	ll that applies)
□ Vaginal delivery □	Pain relief, please specify:
Caesarean section	Anesthesia used, please specify:
Induced labour	Epidural given
Forceps delivery	Neonatal Intensive Care, please provide details:
Fetal distress	Hospitalization in the first year, please provide details:
Low birth weight	
Premature delivery	Nicky Gonis Holistic Health





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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 boxe	es with a tick for present symptoms and a cross for pas
symptoms. Please leave the box blank if your child has nev	
☐ Bloating ☐ Constipation	☐ Diarrhea ☐ Flatulence
Fussy eating Nausea	Reflux Colic
☐ Irregular Bowels ☐ Poor appetite	Burping
☐ Bedwetting ☐ Sleeping problems	Anxiety Hearing problems
Poor concentration. Behaviour issues	Mood swings Learning issues
☐ Autism ☐ Hyperactivity/ADHD	☐ Developmental delays ☐ Speech problems
	☐ Asthma ☐ Diabetes
Eczema/Psoriasis Skin rashes	Sinus problems Heart trouble
Respiratory issues Recurrent antibiotic use	Ear infections
☐ Poor wound healing ☐ Fractures/broken bones	☐ Growing pains ☐ Seizures
Allergies, please specify:	
Recurrent colds/infections, please explain:	
Food intolerances, please list:	
Any other health concerns:	

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Smoking

Vaccination history:

Do the following pertain to your household?

Old home

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Pets

	ate with their vaccines? Please a cross for no next to each vac	circle: YES NO ccination (Please list any others	s 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 (MenB)			
Diphtheria, tetanus acellular pertussis/Whooping cough (DtaP)	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?						
of trust with me, the practition	er. If there is anything further y	entiality. It is very important thaton to the vou would like to discuss with relaxation, please bring the second control of the control of th	_			
Thank you for completing the Nicky Gonis Holistic Health	intake form					

Renovations

