Frackson Health Care
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CONFIDENTIAL 0–2-YEAR-OLD PATIENT INTAKE FORM

Name _____ Preferred name & pronouns _____
Services Card (PHN) _____ Birth date (mm/dd/yyyy) _____/_____/_____
Parent(s)/Guardian(s) Name _____
Address_____ City_____ Postal Code_____
Primary phone _____ Email _____
Primary Healthcare Provider _____

What is your primary concern for your child _____

_____

When did this begin _____

Did it occur: ☐Suddenly ☐Gradually Have they had this or similar conditions in the past: ☐Yes ☐No

If yes, please explain _____

Is the condition: ☐Constant ☐Intermittent Is the condition getting progressively worse? ☐Yes ☐No

Have you consulted any other health care professionals for treatment? If yes, please explain

_____

_____

Please list any hospitalizations, surgeries, major injuries, accidents, falls, motor vehicle accidents, and/or broken bones your child has sustained in their lifetime, including the year _____

_____

Please list **ALL** prescription drugs, over the counter drugs, vitamins and natural supplements your child takes:

_____

Prenatal history

Any complications during pregnancy ☐Yes ☐No

If yes, please explain _____

Did you carry your child to full term? ☐Yes ☐No _____

Did you use any medications during your pregnancy? ☐Yes ☐No

If yes, please describe _____

Please fill out other side

Labour and Delivery

Was your labor: ☐Spontaneous ☐Induced

Childbirth was: ☐Medicated vaginal ☐Un-medicated vaginal ☐Scheduled caesarean ☐Emergency caesarean

Any medications used during labour? _____

Please check off any interventions used during delivery:

☐Forceps ☐Vacuum extraction ☐Internal turn ☐Episiotomy ☐Other _____

In the past six months, has your child experienced any of the following.

S = Sometimes O = Often A = Always

	S	O	A		S	O	A		S	O	A
Doesn't like tummy time				Ear infections				Sleep issues			
Only rolling 1 direction				Digestive issues				Food sensitivities			
Bum scooting				Bowel issues							
Tip toe walking											

Are there any concerns regarding your child's development or behavior? ☐Yes ☐No

If yes, please specify _____

What do you hope to gain from your treatment here? Please check all that apply

☐Resolve existing conditions ☐Guidance for future prevention ☐Overall wellness ☐Other_____

Please keep in mind that your treatment time is reserved specifically for you, A minimum of 24 hours' notice for rescheduling or cancelling appointments is required. There will be a charge of $40 for missed appointments or cancellations without 24 hours' notice.

Please initial in the box to indicate you have read and understood this policy ☐

Thank you for your patience and cooperation in completely filling out this form

Parent/Guardian Signature _____ **Date** _____