Frackson Health Care

frecksonhealthcare@gmail.com

250.382.2225

CONFIDENTIAL 3–10-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 & how did this begin ____

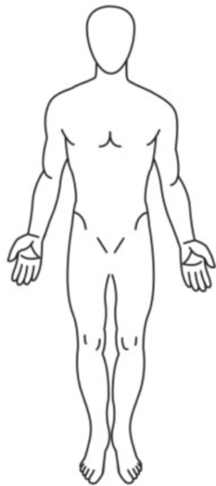
Did it occur: ☐Suddenly ☐Gradually Have they had this or similar conditions in the past: ☐Yes ☐No

If yes, please explain ____

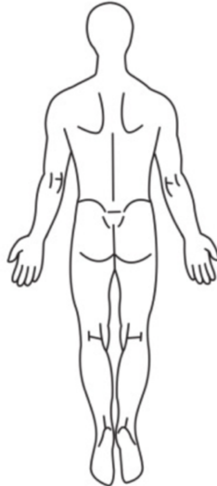
What aggravates the condition ____

What relieves the condition ____

Please mark off the area(s) of the symptoms on the diagram below.



FRONT



BACK

LEFT

RIGHT

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 fill out other side

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:

____

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

If yes, please specify: ____

How many hours of sleep does your child get per day? _______________________________________

How long does your child spend watching a screen (e.g., TV, tablet, phone etc) each day? ____________________

How long does your child spend working at the computer/doing schoolwork each day? ____________________

How much time does your child spend being active each day? ___________________________________

Is your child involved in any sports or extracurricular activities? ☐Yes ☐No

If yes, please specify activities and duration ____

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**
Headaches				Digestive issues				Sleep issues			
Ear infections				Bowel issues				Bedwetting			
Allergies				Food sensitivities							

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** ____________________