Wallace
Integrated Health Centre

Dr. Kelly Wallace, B.Sc., N.D.

Vaccination Consult Intake Form

General information:
Name:_____
Age:_____
Date of birth:_____
Address:_____
_____
_____
Phone:_____

Primary Care Giver:
Name:_____
Relationship to patient: (check)
mother___ father___ relative____
family friend____ other_____
Address:_____
_____
_____
Phone (h):_____
Phone (w):_____

Who does the child live with?_____
What are the parents/care-givers occupations?_____
How many siblings does your child have, and what age are they:_____
_____
Are siblings, or your child in daycare or school? _____
Is your child adopted? Y N
What is your child's ethnic background? _____

Prenatal History:
How was both parents health at conception? Mother: poor fair good unknown
Father: poor fair good unknown

What was mom's age at conception? _____
What was dad's age at conception? _____
What was mom's health like during pregnancy? poor fair good unknown
Has mom contracted, or been vaccinated for:

		Age:	Reaction: (if any)
DTP (diphtheria, tetanus, pertussis)	Y N	___	_____
Tetanus booster	Y N	___	_____
Polio	Y N	___	_____
MMR (measles, mumps, rubella)	Y N	___	_____
Hemophilus influenzae (Hib)	Y N	___	_____
Varicella (chicken pox)	Y N	___	_____
Flu shot	Y N	___	_____
Hepatitis A/B	Y N	___	_____
Pneumococcal disease	Y N	___	_____
HPV (human papilloma virus)	Y N	___	_____

Birth History:
Term length (weeks):_____ Birth weight:_____ Any complications?_____

Type of birth: (vaginal, C- section)

139 Worthington St. E., North Bay, ON, P1B 1G4
Phone: 705-474-2727 Fax: 705-474-5308 www.wallacehealth.com

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How was the infant fed? Breast fed_____ For how long?_____
Formula fed_____ Type of formula (milk, soy, other)_____

How was the child's health at birth? Poor fair good

When were foods introduced? _____
Any food reactions? _____

Medical History:
Surgeries/ Hospitalizations:

Condition:	Year:
_____	_____
_____	_____
_____	_____
_____	_____

Allergies:
Food:_____
Chemical/drug:_____
Other:_____

Condition	***Year***	***Condition***	***Year***
Diaper rash		Chicken pox	
Cradle cap		Measles	
Eczema		Mumps	
Psoriasis		Rubella	
Fever		Lice	
Roseola		Impetigo	
Urinary tract infection		Cold sores	
Frequent colds		Bed-wetting	
Worms		Broken bones	
Warts		Sprains, strains	
Whooping cough		Nightmares	
Constipation		Poor sleep	
Diarrhea		Deafness	
Asthma		Ear infections	
Excessive thirst		Changes in appetite	

Please list any medications, with dosage:
_____
_____
_____
Has your child ever been on antibiotics? _____

Please list any supplements, vitamins…, with dosage:

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_____
_____
_____

What is your child's diet like?

_____
_____
_____
_____

Developmental History:
How was the child's health for the first year: poor fair good unknown
Did your child meet his/her developmental milestones on time? Y N
Are there any pets at home? Y N
Does anyone in the home smoke? Y N
Do you live on a farm? Y N
Does anyone in the home have a chronic disease? Y N _____
Do you plan to travel outside of North America with your child? Y N
Are there needles in your household, where your child might be able to access? Y N

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