



**Quest Community Health Centre  
Pediatric Client Intake and Health History Form  
For Children 0 – 11 years**

We are collecting this information from clients to find out who we serve and what unique needs our clients have. We will also use this information to understand client experiences and outcomes. The information you provide will help us improve quality of care and also plan for services and program development. Completing this form is optional. If you are not comfortable with any of the questions, you can ask for clarification or choose not to answer them.

Date: \_\_\_\_\_

Name of person completing this form: \_\_\_\_\_  
First Last

Relationship to child: \_\_\_\_\_

**REGISTRATION**

Child's Legal Name: \_\_\_\_\_  
First Last

Child's Preferred Name: \_\_\_\_\_  
First Last

Child's Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Child's Sex (on Health Card):  Gender Neutral(X)  
Day Month Year  Female  Male

Health Card No. \_\_\_\_\_ Version Code: \_\_\_\_\_ Expiry date: \_\_\_\_\_

Health Card No. \_\_\_\_\_ Version: \_\_\_\_\_ Expiry Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month / Day / Year

OR This child does not have a health card because:

- Lost /stolen  Forgot to bring  Awaiting acceptance  Other \_\_\_\_\_

**PARENT / GUARDIAN CONTACT INFORMATION**

Who is the legal guardian of this child?

\_\_\_\_\_  
Name Relationship

What is the custody arrangement? (e.g. adopted/foster care/kinship) \_\_\_\_\_

If there is a legal custody agreement, is this a joint custody agreement?  Yes  No

If yes, please explain: \_\_\_\_\_

Guardian's Address: \_\_\_\_\_  
# Street City Province Postal Code

Client No. \_\_\_\_\_

Home Telephone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Preferred  Leave a message  Yes  No

Work Telephone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Preferred  Leave a message  Yes  No

Cell Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Preferred  Leave a message  Yes  No  
Can we contact you through text

Other Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Preferred  Leave a message  Yes  No  
Can we contact you through text

If other phone number provided, who is this individual? \_\_\_\_\_

Email: \_\_\_\_\_ Can we contact you through email

Does the child live at the address above?  Yes  No If no, what is the child's address?

\_\_\_\_\_  
No. Street City Province Postal Code

Emergency Contact: \_\_\_\_\_  
First Name Last Name

Telephone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**ADDITIONAL PARENTS / GUARDIANS / CAREGIVERS / FAMILY MEMBERS/SIBLINGS**

Name	Relationship	Phone Number	Address

**HEALTH CARE HISTORY**

Where has this child been going for health care?

Pediatrician  Family physician  Walk-in clinic  Emergency services  Other \_\_\_\_\_

Name/Facility: \_\_\_\_\_

Address: \_\_\_\_\_  
No. Street City Province Postal Code

Phone No.: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

How did you hear about Quest CHC? \_\_\_\_\_

Other Family Members (e.g. parents, siblings) that attend Quest CHC:

Name	Health Card No.	Date of Birth	Relationship

Is the child interested in participating in virtual appointments/groups?  Yes  No

Is the child able to participate in virtual appointments/groups (eg. technology, understanding)?  
 Yes  No

**SOCIO-DEMOGRAPHIC/ SOCIO-ECONOMIC**

What is the child's gender?  
 Female  Male  Gender Independent

Is the child currently enrolled in school?  Yes  No

If yes, what is the name of the school? \_\_\_\_\_

If yes, what is your current grade? \_\_\_\_\_

What is the approximate yearly combined household income? (Choose the amount that supports the household where the child is living now [eg. Parents/guardians])

- Less than \$14,999 (\$1,249/month)
- \$15,000 – \$19,999 (\$1,249-1,667/month)
- \$20,000 – \$24,999 (\$1,668-2,083/month)
- \$25,000 – \$29,999 (\$2,084-2,500/month)
- \$30,000 - \$34,999 (\$2,501-2,916/month)
- \$35,000 - \$39,999 (\$2,917-3,333/month)
- \$40,000 – \$59,999 (\$3,334-4,999/month)
- over \$60,000 (over 5,000/month)
- Do not know
- Prefer not to answer

How many people are supported by this income? \_\_\_\_\_

Are you struggling to meet your basic needs?  Yes  No

What is/are your source(s) of income?

- Canada Pension Plan (CPP)
- CPP-Disability
- Employment
- Employment Insurance (EI)
- Guaranteed Income Supplement or Ontario Guaranteed Annual Income System (GIS/GAINS)
- Family/Spouse/Friend
- Old Age Security (OAS)
- Ontario Disability (ODSP)
- Ontario Works (OW)
- Spousal/Child Support
- Retirement Income
- WSIB
- None
- Other \_\_\_\_\_

What is your current housing situation? Check ALL that apply.

- With parent(s)
- Foster Care
- Subsidized Housing
- Hotel/Motel
- With grandparent(s)
- Group Home
- House/condo
- Shelter
- With extended family
- Hospital/Respite
- Rental House/Apt
- Living on the Street
- With non-relatives
- Do not know
- Other \_\_\_\_\_

Who lives with you? \_\_\_\_\_

**LANGUAGE**

What is the child's mother tongue?

- English  
 French  
 Other \_\_\_\_\_

Which of Canada's Official Languages is the child most comfortable in?

- English  
 French

In which language is the child most comfortable receiving your healthcare services? \_\_\_\_\_

**BACKGROUND**

Which of the following would best describe your racial or ethnic group? Check ONE only.

- |   |   |
|---|---|
| <input type="checkbox"/> Asian – East (eg. Chinese, Japanese, Korean)             | <input type="checkbox"/> Latin American (eg. Argentinean, Chilean, Salvadoran)        |
| <input type="checkbox"/> Asian – South (eg. Indian, Pakistan, Sri Lankan)         | <input type="checkbox"/> Metis  |
| <input type="checkbox"/> Asian – South East (eg. Malaysian, Filipino, Vietnamese) | <input type="checkbox"/> Middle Eastern (eg. Egyptian, Iranian, Lebanese)             |
| <input type="checkbox"/> Black – African (eg. Ghanaian, Kenyan, Somali)           | <input type="checkbox"/> White – European (eg. English, Italian, Portuguese, Russian) |
| <input type="checkbox"/> Black – Caribbean (eg. Barbadian, Jamaican)              | <input type="checkbox"/> White – North American (eg. Canadian, American)              |
| <input type="checkbox"/> Black – North American (eg. Canadian, American)          | <input type="checkbox"/> Mixed Heritage (eg. Black –Africa & White-North American)    |
| <input type="checkbox"/> First Nation   | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Indian – Caribbean (eg. Guyanese with origins in India)  | <input type="checkbox"/> Do not know  |
| <input type="checkbox"/> Indigenous/ Aboriginal – not included elsewhere          | <input type="checkbox"/> Prefer not to answer   |
| <input type="checkbox"/> Inuit  |   |

Was the child born in Canada?

- Yes  
 No  
 Prefer not to answer  
 Do not know

If no, what year did the child arrive in Canada? \_\_\_\_\_If no, what country was the child born in? \_\_\_\_\_

What is the child's citizenship status?

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> Canadian Citizen   | <input type="checkbox"/> Refugee Claimant  | <input type="checkbox"/> Visitor Visa |
| <input type="checkbox"/> Landed Immigrant   | <input type="checkbox"/> Sponsored Refugee | <input type="checkbox"/> Work Visa    |
| <input type="checkbox"/> No Status          | <input type="checkbox"/> Student Visa      | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Permanent Resident |  |                                       |

What is the child's religious or spiritual affiliation?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> I do not have one    | <input type="checkbox"/> Jehovah's Witnesses | <input type="checkbox"/> Other: _____         |
| <input type="checkbox"/> Animism or Shamanism | <input type="checkbox"/> Judaism             | <input type="checkbox"/> Do not know          |
| <input type="checkbox"/> Atheism              | <input type="checkbox"/> Native Spirituality | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Baha'i Faith         | <input type="checkbox"/> Pagan               |   |
| <input type="checkbox"/> Buddhism             | <input type="checkbox"/> Protestant          |   |
| <input type="checkbox"/> Christian            | <input type="checkbox"/> Rastafarianism      |   |
| <input type="checkbox"/> Christian Orthodox   | <input type="checkbox"/> Roman Catholic      |   |
| <input type="checkbox"/> Confucianism         | <input type="checkbox"/> Sikhism             |   |
| <input type="checkbox"/> Hinduism             | <input type="checkbox"/> Spiritual           |   |
| <input type="checkbox"/> Islam                | <input type="checkbox"/> Unitarianism        |   |
| <input type="checkbox"/> Jainism              | <input type="checkbox"/> Zoroastrianism      |   |

**DISABILITY**

Do you have any of the following disabilities?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Chronic Illness            | <input type="checkbox"/> Mental Illness                                   | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Developmental Disability   | <input type="checkbox"/> Physical Disability                              | <input type="checkbox"/> Do not know          |
| <input type="checkbox"/> Drug or alcohol dependence | <input type="checkbox"/> Sensory Disability (i.e. hearing or vision loss) | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Learning Disability        |   |   |

**WELLBEING**

How would you describe your physical health?

- Not sure    Poor    Fair    Good    Very Good    Excellent

How would you rate your mental health?

- Not sure    Poor    Fair    Good    Very Good    Excellent

How would you describe your sense of belonging to the community?

- Very Weak    Somewhat Weak    Somewhat Strong    Very Strong

**TRANSPORTATION**

How will the child get to your appointments? \_\_\_\_\_

Do you experience any difficulties in transportation? \_\_\_\_\_

**Pediatric Health History Form**

**MEDICAL HISTORY**

Has this child attended regularly scheduled Doctors visits? (e.g. 2,4,6 month visits)    Yes    No

When did the child have their last medical check-up? \_\_\_\_\_

Does this child have any chronic medical conditions?    Yes    No

If yes, please explain: \_\_\_\_\_

Has this child ever had an operation?    Yes    No

If yes, please explain: \_\_\_\_\_

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What is this child's current height? \_\_\_\_\_ What is the child's current weight? \_\_\_\_\_

Has this child ever been admitted to the hospital?  Yes  No

If yes, please explain: \_\_\_\_\_

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Does this child receive routine dental care?  Yes  No

If no, please explain: \_\_\_\_\_

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### **EMOTIONAL HISTORY**

Check any of the following that relates to this child:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Abuse/<br>violence                  | <input type="checkbox"/> Difficulty learning                        | <input type="checkbox"/> Self-harm behaviour                        | <input type="checkbox"/> Grief/death   |
| <input type="checkbox"/> Bullying                            | <input type="checkbox"/> Poor concentration                         | <input type="checkbox"/> Suicidal thoughts/<br>attempts             | <input type="checkbox"/> Feeling depressed                                     |
| <input type="checkbox"/> Anger issues                        | <input type="checkbox"/> Hyperactivity                              | <input type="checkbox"/> Extreme guilt or shame                     | <input type="checkbox"/> Feeling anxious                                       |
| <input type="checkbox"/> Low self-<br>esteem                 | <input type="checkbox"/> Poor impulse<br>control                    | <input type="checkbox"/> Severe mood swings                         | <input type="checkbox"/> Stress  |
| <input type="checkbox"/> Sexual assault                      | <input type="checkbox"/> Difficulty controlling<br>emotions         | <input type="checkbox"/> Hoarding                                   | <input type="checkbox"/> Panic/anxiety attacks                                 |
| <input type="checkbox"/> Physical<br>assault                 | <input type="checkbox"/> Difficulty<br>maintaining<br>relationships | <input type="checkbox"/> Poor memory                                | <input type="checkbox"/> Flashbacks, night<br>terrors or intrusive<br>thoughts |
| <input type="checkbox"/> Verbal assault                      |   | <input type="checkbox"/> Easily startled or hyper<br>vigilant       | <input type="checkbox"/> Death by suicide of<br>family member or<br>friend     |
| <input type="checkbox"/> Overly<br>suspicious or<br>paranoid |   | <input type="checkbox"/> Hearing voices or<br>having hallucinations |  |

### **MEDICATIONS**

Does this child take any medications?  Yes  No

If yes, please explain: \_\_\_\_\_

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### **ALLERGIC REACTIONS**

Does this child have any allergies?  Yes  No

If yes, please explain: \_\_\_\_\_

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### **IMMUNIZATIONS**

Does the child have an immunization record?  Yes  No  Don't know

Client No. \_\_\_\_\_

What was the last immunization that they have received? \_\_\_\_\_

Does this child have any special dietary needs?  Yes  No

If yes, please explain: \_\_\_\_\_

**PRENATAL/DELIVERY INFORMATION**

What was this child's birth weight? \_\_\_\_\_ What was the child's birth length? \_\_\_\_\_

Were there any complications with pregnancy or delivery?  Yes  No

If yes, please explain: \_\_\_\_\_

How many weeks was the child at delivery?

Premature baby (28 - 36 weeks)  Full term baby (after 37 weeks)  Other: \_\_\_\_\_

Is the child a:  Single  Twin  Multiple

What was the Mother's age at the time of birth? \_\_\_\_\_

During the pregnancy, was there any use of:  Alcohol  Drugs  Tobacco

What was the frequency of use? \_\_\_\_\_

**COMMUNITY CONNECTIONS**

Is the child interested in finding ways to connect with new people and activities in the community?

Yes  No

If yes, what type of activities does the child enjoy? \_\_\_\_\_

Does this child have other community supports? (e.g. FACS, Pathstones)  Yes  No

Name of organization:	Worker/counselor's name:	Phone number:

Client No. \_\_\_\_\_

The above is accurate to the best of my knowledge. I consent to this child's treatment, and agree to participate in reaching the child's health care goals in partnership with Quest Community Health Centre.

**Quest CHC Client Rights/Responsibilities was reviewed with client/guardian?**

Yes  No

**Statement of Personal Health Information Practices was reviewed with client/guardian?**

Yes  No

**Consent to the Collection, Use & Disclosure of Personal Health Information was reviewed/signed by client/guardian?**

Yes  No

**Consent to Electronic Communication was reviewed/signed by client/guardian?**

Yes  No

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Quest CHC Provider who reviewed Client History

\_\_\_\_\_  
Date

Quest CHC "Client Rights" reviewed with parent/guardian?  Yes  No

Consent for Personal Health Info signed by parent/guardian?  Yes  No

\*\*First appointment for Well Baby Visit is to be booked with an RN. \*\*