



(https://www.laurasheehan.com)

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Profile Information — Step 1 of 3

You are completing the intake form: **Intake Form (Babies and Children)** for **

Please take a moment to fill out our online intake form before your visit. All information is kept completely confidential. Please fill out to the best of your ability. Some questions may only pertain to babies and some to children.

Only staff members can edit this information on an intake form.

First Name – *Required*

Last Name – *Required*

Preferred Name (if different)

Mobile Phone



Please provide at least one phone number. Your mobile number can be used to look up your Account and receive text message appointment reminders.

Home Phone



Country

Street Address

Suite Number (i.e. Suite #100)

City

State

Postal / Zip

Date of Birth

Gender

Refers to current gender which may be different than what is indicated on your insurance policies or medical record.

Sex

This field may be used for submitting claims to your insurance provider. Please ensure the sex you provide here matches what your insurance provider has on file or what is indicated on your medical record.

Personal Health Number

Guardian

Emergency Contact

Emergency Contact Phone

Emergency Contact Relationship

Family Doctor

Family Doctor Phone (if known)

Family Doctor Email (if known)

Name of referring professional

Referring professional phone (if known)

Referring professional email (if known)

How did you hear about us?

Continue

Questionnaires — Step 2 of 3

You are completing the following intake forms: Intake Form (Babies and Children)

Intake Form (Babies and Children)

Medical Information

About Patient

Current Age:	<input type="text"/>
Current Weight:	<input type="text"/>
Current Height:	<input type="text"/>

Has this condition

gotten worse stayed constant comes and goes

Has this condition occurred before?

Yes

No

Allergies, if known (medical, environmental, foods)

Dietary Restrictions, if any (religious/vegetarian/vegan)

Number of anti-biotic treatments

Screening tests your child has had, if applicable

(e.g., blood, hearing, vision)

Current Medication(s) & dosage

(e.g., prescription, over-the-counter, vitamins, herbs, etc..)

Prescription, over-the-counter, vitamins

Past medication(s) & dosage

Past serious conditions, illnesses, injuries and/or hospitalizations & dates

Child's general state of health



Other medical conditions?

Family and Health History Information

Family Health History - Has a close relative (parent, grandparent, sibling) has had any of the following

Unknown (e.g., adoption, no record)

Allergies

Arthritis

Asthma

Cancer (if yes, please note type)

Diabetes

Eczema

Kidney disease

Skin disease

Tuberculosis

Other (Please describe)

Which, if any, of the following illnesses and to which intensity has your child had?

Chicken Pox

Ear Infections

Impetigo

Measles

Mononucleosis

Mumps

Roseola

Rubella

Scarlet fever

Strep throat

Whooping cough

Immunization History

MMR (mumps, measles, rubella)

DPT (diphtheria, pertussis, tetanus)

"Flu"

Haemophilus influenza B

Hepatitis A

Hepatitis B

Polio

My child has not been immunized

Is there a history of adverse reaction(s) to immunization(s)?

Yes No

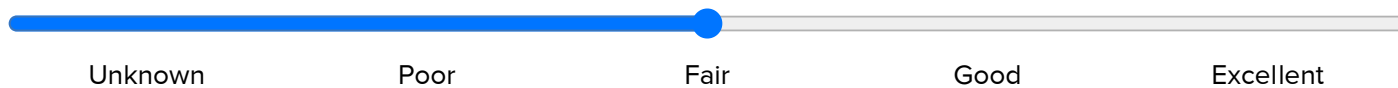
If Yes, please describe the reaction

Prenatal Health of Parents

Health of Mother at conception



Health of Mother during pregnancy



Diet of Mother during Pregnancy (very generally)

Breakfast

Lunch

Snacks

Dinner

Beverages (type and amount)

Were any of the following used by the Mother during pregnancy?

Tobacco

Alcohol

Prescription drugs/medication(s)

Over the counter drugs/medication(s)

Supplement(s)

Recreational drugs

Other (Please describe)

Were any of the following experienced by the Mother during pregnancy?

Bleeding

Diabetes

High blood pressure

Nausea

Thyroid problem

Trauma, physical or emotional

Vomiting

Other (Please describe)

Did the Mother receive prenatal care?

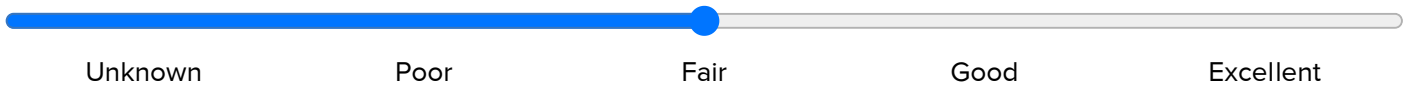
Yes

No

Unknown

Mother's age at child's birth?

Health of Father at conception



Birth History



Method of delivery

Vaginal C-Section Induced Forceps Vacuum Anesthesia

Were any of the following experienced by the child at or shortly after birth?

Birth defect(s)

Birth Injury

Jaundice

Rashes

Seizures

Other complications (Please describe)

Diet, Development and Environmental Information

Was the child breast fed? how long?

Formula? Which type? (e.g., milk, soy)

Foods introduced before 6 months, with month if known

Foods introduced at 6-12 months

Did your child ever experience colic? If yes, please describe severity

Dietary Restrictions, if any (religious/vegetarian/vegan)

Typical diet, generally

Breakfast

Lunch

Dinner

Snacks

Beverages, type & amount

Health & Development

Child's health in the first year



Poor

Fair

Good

Excellent

At what age did your child first, if known & applicable

Sit up

Walk

Crawl

Talk

Describe your child's sleeping patterns

Describe your child's temperament

Describe your child's behavior and performance at school (if applicable)

Environment

Child attends

Home care

Daycare

School

Home school

other

Child's parents are

Married

Separated

Divorced

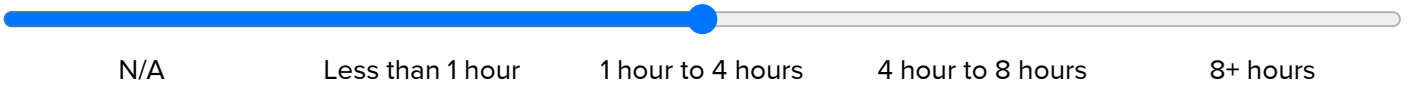
Other

If parents do not live in the same home, what is the living arrangement for the child?

Does the child exercise regularly?



How much screen time does your child have per week?



Length of time that the child reads, or is read to per week



Does anyone in the child's household smoke?

Yes No

Are there pets/animals in the home?

Yes

No

How is the child's home heated?

Are there toxins or other hazards the child is regularly exposed to?

How would you describe the emotional climate of the child's home?

Any other environmental factors, not covered?

Consents — Step 3 of 3

You are completing the following intake forms: Intake Form (Babies and Children)

Email Communication

Transactional Emails

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

I would like email notifications of new, cancelled, and rescheduled appointments

News and Special Promotions

Yes, I would like to receive news and special promotions by email

Intake Form (Babies and Children) — Consents

Accuracy of Information

I certify that the above medical information is correct to my knowledge. – *Required*

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

I agree – *Required*

Cancellation policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in Dr. Sheehan's day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee.

I am aware of the Cancellation Policy. – *Required*

Please check that all required questions have been answered.

Submit Intake Form

(<https://jane.app>)

