Pediatric Intake Form

WELCOME! It is our goal to provide your child with the best possible health care. In order to serve you optimally, please answer the following questions about your child’s health history and lifestyle

Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex M F Number where we may leave messages\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of which parent? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list current health concerns:

1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Medications** | Current | Past  | Frequency | **Supplements** | Current | Past | Dose |
| **Aspirin** |  |  |  | **Vitamins** |  |  |  |
| **Tylenol** |  |  |  | **Minerals** |  |  |  |
| **Antibiotics** |  |  |  | **Herbs** |  |  |  |
| **Decongestants** |  |  |  | **Fluoride** |  |  |  |
| **Other** |  |  |  | **Homeopathy** |  |  |  |

Childhood illnesses:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Chicken pox |  Germanmeasles |  Mumps |  Polio |  Tonsillitis |
| Diphtheria |  Measles |  Pertussis |  Rheumatic Fever |  Scarlet Fever |
| Ear infections | Mononucleosis |  Pneumonia |  Rubella |  Strep Throat |

|  |  |  |
| --- | --- | --- |
| Immunizations | Date | Adverse reactions |
|  DTP or DTap |  |  |
|  MMR |  |  |
|  Polio(IPV/OPV) |  |  |
|  Hib |  |  |
|  Pneumococcus (PCV0 |  |  |
|  Hep B |  |  |
|  Varicella |  |  |
| Tb test (pos. or neg?) |  |  |

Allergies and Sensitivities

|  |  |
| --- | --- |
| **Drugs,Foods,Environment,Chemicals,ETC** | **Symptom during an allergy attack?** |
|  |  |
|  |  |
|  |  |
|  |  |

Hospitalizations/Surgeries/Accidents/Serious Injuries and Illnesses:

|  |  |  |
| --- | --- | --- |
| Incident | Date  | Details |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Family History: (Identify all family members who have or have had any of the following)

Alcoholism\_\_\_\_\_\_\_\_\_\_\_ Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_ Hypoglycemia \_\_\_\_\_\_\_\_\_\_\_

Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_  Eczema \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mental Illness \_\_\_\_\_\_\_\_\_\_\_

Anemia \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Epilepsy \_\_\_\_\_\_\_\_\_\_\_\_\_ Obesity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Arthritis \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Heart disease \_\_\_\_\_\_\_\_\_\_ Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hearing loss \_\_\_\_\_\_\_\_\_\_ Thyroid Disorder \_\_\_\_\_\_\_\_\_

Birth Defects \_\_\_\_\_\_\_\_\_\_ High Blood Pressure \_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any of the above that your child has \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health History: Circle the response that applies: Y= a current condition P=a past condition

Acne Y P Depression Y P High Fever Y P

Allergies Y P Diarrhea Y P Hyperactivity Y P

Anemia Y P Dizziness Y P Insomnia Y P

Asthma Y P Earaches Y P Jaundice Y P

Bed Wetting Y P Eczema Y P Learning Disorder Y P

Birth Defects Y P Seizures Y P Moodiness Y P

Colic Y P Fatigue Y P Stuffy Nose Y P

Constipation Y P Frequent Infections Y P Vomitting Spells Y P

Cough Y P Headaches Y P Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Craddle Cap Y P Heart Murmur Y P \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your child’s general disposition?

Prenatal/Birth /Feeding History:

Mother’s health during pregnancy: (check; then describe below) Age at pregnancy \_\_\_\_\_

Alcohol consumption Nausea Toxemia

Bleeding Recreational drugs Trauma/ Injury

High Blood pressure Smoking X-Ray

Medications Stress

Other Illness :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was pregnancy Easy Difficult Term: Full Premature Late Birth weight: \_\_\_\_\_\_\_

Explain:

Place of Birth : Hospital Home Birth Center Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Feeding:

 Breast fed How long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Formula Fed How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Type of formula\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Cow’s milk?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age Solid Foods Begun\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First foods \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sample Daily Diet: (choose a typical day and include foods and liquids)

Social History:

Parents : Married Separated Divorced

 Other guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_\_\_

 Others Residing in Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_

Daycare/Preschool/School? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours each day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Days of the week?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings:NAME AGE HEALTH PROBLEMS

1)

2)

3)

4)

Interactions with relatives :Who \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any other health concerns you would like to discuss?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that the information that I have supplied is correct and accurate to the best of my knowledge

Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_