

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 _____

Birth date _____ Sex: F M Number where we may leave messages: _____

Present Health Concerns	Date of Onset	Current Treatment

Allergies and Sensitivities

Drugs, Foods, Environmental, Chemicals, Etc	Symptoms during an allergy attack?

Treatments

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

Past Illnesses:

€ Chicken Pox	€ Pneumonia
€ Diphtheria	€ Polio
€ Ear Infections	€ Rheumatic Fever
€ German Measles	€ Rubella
€ Measles	€ Tonsillitis
€ Mononucleosis	€ Scarlet Fever
€ Mumps	€ Strep Throat
€ Pertussis	

Immunizations

Immunizations	Date	Adverse Reactions
<input type="checkbox"/> DTP or <input type="checkbox"/> DTaP		
<input type="checkbox"/> MMR		
<input type="checkbox"/> Polio (<input type="checkbox"/> IPV/ <input type="checkbox"/> OPV)		
<input type="checkbox"/> Hib		
<input type="checkbox"/> Pneumococcus (PCV)		
<input type="checkbox"/> Hep B		
<input type="checkbox"/> Varicella		
<input type="checkbox"/> TB test (pos. or neg?)		
<input type="checkbox"/>		

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)

- | | | |
|----------------------------------------------|----------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Alcoholism _____ | <input type="checkbox"/> Eczema _____ | <input type="checkbox"/> Obesity _____ |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Thyroid Disorder _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Hearing Loss _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> High Blood Pressure _____ | |
| <input type="checkbox"/> Birth Defects _____ | <input type="checkbox"/> Hypoglycemia _____ | |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Mental Illness _____ | |
| <input type="checkbox"/> Diabetes _____ | | |

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	Vomiting Spells	Y	P
Cough	Y	P	Headaches	Y	P	Other _____		
Cradle Cap	Y	P	Heart Murmur	Y	P			

Prenatal/Birth/Feeding History:

Mother's health during pregnancy: (check; then describe below)

Age at pregnancy _____

- | | | |
|-----------------------------------------------|---------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Alcohol Consumption | <input type="checkbox"/> Nausea | <input type="checkbox"/> Toxemia |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Recreational Drugs | <input type="checkbox"/> Trauma/Injury |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Smoking | <input type="checkbox"/> X-Ray |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Stress | |
| <input type="checkbox"/> 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 _____

Age of Introduction for: milk _____ wheat _____ Favorite Foods _____

Sample Daily Diet: (Choose a typical day and include food and liquids)

What is your child's general disposition?

Social History:

Parents: Married Civil Union 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)

Interaction 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 _____ Relationship to Patient: _____

Signature _____ Date _____