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(s) 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
☐ DTP or ☐ DTaP		
☐ MMR		
☐ Polio (☐ IPV/ ☐ OPV)		
☐ Hib		
☐ Pneumococcus (PCV)		
☐ Hep B		
☐ Varicella		
☐ TB test (pos. or neg?)		
☐		

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 ___________
- ❑ Allergies _____________
- ❑ Anemia ______________
- ❑ Arthritis _____________
- ❑ Asthma ______________
- ❑ Birth Defects _________
- ❑ Cancer ________________
- ❑ Diabetes _____________
- ❑ Eczema __________________
- ❑ Epilepsy _________________
- ❑ Heart Disease ___________
- ❑ Hearing Loss ____________
- ❑ High Blood Pressure ___________________
- ❑ Hypoglycemia___________
- ❑ Mental Illness____________
- ❑ Obesity __________________
- ❑ Stroke_________________
- ❑ Thyroid Disorder _________
- ❑ Other _____________________

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________

- ❑ Alcohol Consumption
- ❑ Bleeding
- ❑ High Blood Pressure
- ❑ Medications
- ❑ Nausea
- ❑ Recreational Drugs
- ❑ Smoking
- ❑ Stress
- ❑ Toxemia
- ❑ Trauma/Injury
- ❑ X-Ray
- ❑ 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 ____________________________