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Pediatric Intake Form

Name: _____Date: _____
(First) (Middle) (Last)
Address: _____ City:_____ State: _____ Zip: _____
Date of Birth:_____ Current Age:_____ Gender:_____
Mother's Name:_____ Father's Name:_____
Home Phone:_____ Parent's Cell Phone:_____
Parent's Email:_____

Emergency Contact:_____ Telephone:_____ Relationship:_____

Whom may we thank for referring you to us? _____

Successful health care is only possible when the practitioner has a thorough understanding of the patient physically, mentally, and emotionally. Please complete the following questionnaire as thoroughly as possible.

Is your child currently receiving health care: [Yes] [No]
If yes, where and from whom? _____
If no, When and where did you last receive health care?_____
For what reason?_____

Please identify below the health concerns that have brought you to the clinic:
Condition Past Treatment
1_____
2_____

Primary Health Concern:
When condition began: _____ Have you had this in the past? [Yes] [No]
Is your condition: [ ] Getting worse [ ] Staying constant [ ] Coming & going
What makes it better? _____
What makes it worse? _____
What diagnosis have you been given? _____
What kinds of treatment have you tried? _____

Secondary Health Concern:
When condition began: _____ Have you had this in the past? [Yes] [No]
Is your condition: [ ] Getting worse [ ] Staying constant [ ] Coming & going
What makes it better? _____
What makes it worse? _____
What diagnosis have you been given? _____
What kinds of treatment have you tried? _____

Height: _____ Weight: _____ Blood Pressure _____/_____

Does your child have any chronic infectious disease? [Yes] [No]
If yes, please explain: _____
Is your child suffering from any chronic illnesses? [Yes] [No]
If yes, please explain: _____

Significant diseases, injuries, hospitalizations, surgeries, X-rays/CAT scans/MRI's/NMR's/etc
Reason When Results (if applicable)
_____
_____
_____

Please list any prescription medications, over-the-counter medications, vitamins or supplements that your child is currently taking:

Medication/Vitamin/Supplement Dosage Frequency Reason
_____
_____
_____

Please list any past prescription medications: _____
_____

Please list any foods, drugs, substances, or medications your child is hypersensitive or allergic to:
_____

Immunizations (please circle any that your child has had):
Polio Tetanus Measles/Mumps/Rubella Pertussis Diphtheria Hepatitis B Influenza
Prevnar Chicken Pox Others: _____
Any adverse reactions to vaccines? [Yes] [No] If yes, please describe: _____

Family History	Mother	Father	Brother(s)	Sister(s)
Age [if living]				
Health [G=good, P=poor]				
Age at death [if deceased]				
Cause of death				
Family Illnesses	Mother	Father	Brother(s)	Sister(s)
Allergies				
Asthma				
Birth Abnormality				
Cancer				
Celiac Disease				
Diabetes				
Eczema				
Heart Disease				
High Blood Pressure				
Kidney Disease				
Mental Illness				

Birth Mother's Prenatal History-

Mother's age at child's birth? _____ Mother's health during pregnancy? _____
Were any of the following experienced during pregnancy?
[Bleeding] [Physical or emotional trauma] [High blood pressure] [Nausea/Vomiting]
[Depression/Anxiety] [Thyroid problems] [Illnesses] [Gestational diabetes]
Consumption of: [Cigarettes] [Alcohol] [Drugs]
Surgery: _____
Other: _____

Child's Birth History-

Term: [Premature] _____ weeks [Full] [Late] _____ weeks
Length of labor: _____ Any complications? _____
_____
Delivery: [Vaginal] [C-section] [Induced] [Forceps] [Suction] [Anesthesia used]
At birth: Weight _____lbs. _____oz. Height _____inches
Did your child have any of the following problems shortly after birth?
Birth abnormality _____ Birth injuries _____
[Blue baby] [Cerebral palsy] [Seizures] [Jaundice] [Colic] [Fever] [Rashes]
Other: _____

Feeding & Development-

Breastfed? [Yes] [No] If yes, how long? _____ Reason discontinued_____
Formula? [Yes] [No] If yes: [cow's milk] [soy] [other]_____
Age began solids _____ which food? _____
Age began: Sitting_____ Crawling_____ Walking_____ Talking_____
Age your child: Cut their first tooth_____ Lost their first tooth_____
Any deviations off of the standard expected growth chart for height/weight? [Yes] [No]
If yes, please describe: _____
How would you describe your child's temperament? _____

Energy and Immunity- please circle any that apply

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue
Catch Colds Easily Suppressed Immune System History of Antibiotic Usage

Head, Eye, Ear, Nose & Throat- please circle any that apply

Glasses Eye Strain Eye Pain Red/Itchy Eyes See Floating Black Spots Night Blindness
Ear Ringing Poor Hearing Ear Aches Headaches/Migraines Concussions Mouth Sores
Swollen Glands Sinus Problems Frequent Sore Throat TMJ/Jaw Problems Dry Mouth
Teeth Problems Gum Problems Hay Fever/Allergies Other_____

Respiratory- please circle any that apply

Pneumonia Frequent Common Colds Difficulty Breathing Persistent Cough Asthma
Bronchitis Difficulty Breathing When Lying Down Other_____

Genito-Urinary Tract- please circle any that apply

Nighttime Urination History of Kidney Stone Other_____
<u>Urine Color:</u> Normal / Clear / Dark Yellow / Reddish / Cloudy
<u>Urine Flow:</u> Scanty / Has Odor / Burning / Painful / Difficult / Urgent

Gastrointestinal- please circle any that apply

Nausea/Vomiting Epigastric Pain Abdominal Pain Heartburn Gas/Bloating Low Appetite
Large Appetite Bad Breath Fatigue After Eating
Stools: Hard Soft Formed Loose Sticky Black Blood Mucus Undigested Food
Floats Sinks Frequency of Bowel Movements _____ X [Day] [Week]

Sleep-

# of Hours of nighttime sleep: _____ Fall asleep _____AM/PM Wake up _____ AM/PM
Naps: [Yes] [No] If yes, what time and for how long? _____
Difficulty Falling Asleep Why? _____
Difficulty Staying Asleep Waking When? _____
Dreams [Yes] [No] Sleep Quality [Good] [Poor] Wake Feeling Rested [Yes] [No]

Lifestyle-

a. Please indicate typical food and beverage intake:

Breakfast	Lunch	Dinner	Snacks

b. Any dietary restrictions (religious, vegetarian, vegan, etc.)? _____
c. Quantity of Fluids Consumed Daily: Water _____ Other _____
d. Exercise – Type: _____ How often: _____
e. Approximate TV/Computer/Electronics hours per day: Homework _____ Play _____
f. Other _____

If your child has begun or gone through puberty, please continue. If not, then you are done.

Female Reproductive- please circle any that apply

Age of first period _____ Date last period began _____ Date of last PAP _____
Average number of days of flow _____ Average number of days in cycle _____
Is menses regular? [Yes] [No] The flow is: [ ] Heavy [ ] Normal [ ] Light
Average # of tampons/pads used per day: 1st____ 2nd ____3rd _____ 4th _____ 5th _____ 6th _____ 7th _____
The color is: [ ] Fresh Red [ ] Dark Red [ ] Pale Red [ ] Purple [ ] Brown [ ] Other
Do you have the following menstruation related signs/symptoms?

[ ] Bleeding between cycles [ ] Nausea
[ ] Breast distention/tenderness [ ] PMS
[ ] Heavy vaginal discharge between periods [ ] Cramps
[ ] Pelvic pain [ ] Blood clots

Sexually active [Yes] [No] Pregnant/possibility of pregnancy? [Yes] [No] # of weeks _____

Male Reproductive- please circle any that apply

Premature Ejaculation External Genitalia have sensations of : Cold / Numbness / Pain / Swelling
Erectile Dysfunction Prostate Problems Sexually active [Yes] [No] Other_____