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Pediatric Intake Form

Name____ **Preferred Name:________________**
Date of birth _____________________ Age ______ Sex M or F
Grade in School:____
Address: ____
City:__________________ State:_______________ Zip:_____________
Mother's Name and occupation: ____
Father's Name and occupation: ____
Parents are (circle): Married Separated Divorced Living Together Other

Regular Pediatrician name and city located in:____

Reason for today's Office Visit:____

Has child been seen by any other doctor(s) for this complaint? Yes No Past

Has child had any blood work done? If yes, please list what:

____

Please list any operations or hospitalizations and year occurred:
1.
2.
3.

Please list all medicines (from drugstore or prescription) child is on now:
1.
2.
3.
4.

Please list all supplements child is taking:
1.
2.
3.
4.

Any known Allergies to food, drugs, environment, animals and their reaction (*e.g. peanuts causes hives*):

____
____
____
____

Client Name:______________________________ DOB: ______________

Previous medical history

Yes indicates the child gets the problem regularly; **No** indicates the child never had the problem; **P**ast indicates the child had the problem in the past but not recently. Please circle the correct one for your child.

Ear Infections?	Yes	No	Past	If has had, how many total?	___________
Colds?	Yes	No	Past	If has had, how many total?	___________
Strep throat?	Yes	No	Past	If has had, how many total?	___________

How many times has the child taken antibiotics:_______________________________________

What other medicines has the child taken? And how often?

1.

2.

3.

4.

Hearing tests Normal:	Yes	No	Not Tested
Vision Tests Normal:	Yes	No	Not Tested
Any speech impediments:	Yes	No	Past
Learning impediments:	Yes	No	Don't know

Vaccination History: Yes, has had; **No**, has not; **Some**, did not finish all shots

MMR:	Yes	No	Some	DPT:	Yes	No	Some
Hep B:	Yes	No	Some	Hib:	Yes	No	Some
Chickenpox:	Yes	No	Some	Polio:	Yes	No	Some

Other:______________________________

Any reactions to vaccinations? If so, please explain: _______________________

____

Family history

Allergies:	Yes	No	Obesity:	Yes	No
Cancer:	Yes	No	Tuberculosis:	Yes	No
Cardiovascular disease:	Yes	No	Mental Illness:	Yes	No
Diabetes mellitus:	Yes	No			

Client Name:________________________________ DOB: _______________

Mother's Pregnancy history

Age at conception:__________

Did she have other children already? Yes No

Mother's Health During Pregnancy

Smoking:	Yes	No	Diabetes:	Yes	No
Coffee:	Yes	No	Nausea/Vomiting:	Yes	No
Recreational drugs:	Yes	No	Emotional Stress:	Yes	No
Preeclampsia:	Yes	No	Length of Labor:	___________	
Vaginal birth:	Yes	No	Traumatic birth:	Yes	No

If the birth was difficult, please explain:

____

Child's Birth Weight: :_______________

Health of baby at birth:____

Child breastfed: Yes No For how long:___________________________

When put on formula:_______________ What formula was used:_________________

When was child put on solid food:______________________

When did child walk:______________________ Talk:_________________

When did child develop teeth:___________________________

Health History of child

Jaundice as baby:	Yes	No	Colic:	Yes	No
Cradle cap:	Yes	No	Anemia:	Yes	No
Eczema or psoriasis:	Yes	No	Asthma:	Yes	No
Diarrhea:	Yes	No	Warts:	Yes	No
Constipation:	Yes	No	Nightmares:	Yes	No
Finicky eating:	Yes	No	Bed-wetting:	Yes	No
Poor teeth:	Yes	No	Tantrums:	Yes	No
Chronic sniffles:	Yes	No	Disobedient:	Yes	No
Bad foot odor:	Yes	No	Fears/Phobia:	Yes	No
Very sweaty baby/child:	Yes	No	Diaper Rash:	Yes	No
Hyperactivity:	Yes	No	Early Puberty:	Yes	No
Growing pains:	Yes	No	Stomach aches:	Yes	No

Client Name:________________________________ DOB: _______________

Any particular household stressors child has witnessed or gone through:

1.____

2.____

Diet

Foods**:** Please list in each food group, the foods that your child currently eats. Grain would include all breads, pasta and other related foods.

Meat:	Fruit:	Veg:	Grain:
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

Other: ____________ ____________ ____________ ____________

Typical Day's Diet:

Breakfast:____

Snack:____

Lunch:____

Snack:____

Supper:____

Snack:____

Toxin Exposure:

Has the child ever lived near a refinery or other highly polluted area?_______________________

Has the child ever lived in a house with lead paint?_______________________________________

Has the child ever lived in a house that had new paint, cabinets, carpeting installed and did that seem to affect their health at all?____

Do you spray pesticides or herbicides around the house or use other toxic chemicals?

____

Does the child seem particularly sensitive to perfumes or other vapors?____________________

Additional Comments can be noted on back of last page.

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