Dr. Toni Varela, NMD

939 Hartz Way, Ste 100 Danville, CA 94526 •
(925)786-0375

PEDIATRIC INTAKE FORM (6 – 12 YEARS)

Welcome to your first visit. Enclosed is a complete intake form to submit prior to your visit. You can email it to the clinic beforehand or bring it with you to the office visit. Thank you for taking valuable time to fill out the intake.

Patient's Name: ________________________________ Date: _________

Age: ______ Date of Birth: ______________ Gender: Female Male

Parent/Guardian's Name: ___________________ Insurance Plan:___________

Address: ____

Telephone (home): ____________ (Parent's work):_______________________

Parent(s) email address:

____

How did you hear about this clinic?_______________________________

Name of doctor's office/hospital/clinic where your child's health records are kept:

____

____

What is your child's health concerns? List in order of importance.

1)____

2)____

3)____

4)____

5)____

Birth city, state: ____________ Birth weight _____________

Does your child have any contagious diseases? Yes No

If yes, what? ___________________________________

FAMILY HISTORY (check all that apply)

X	Condition	X	Condition
	Heart Disease		Arthritis
	Hypertension		Allergies
	Cancer		Osteoporosis
	Mental Illness		Birth Defects
	Diabetes		Asthma
	Tuberculosis		Other:

Medical History (check any that your child has or has had)

X	Condition	X	Condition	# of infections
	Chicken Pox		Tonsillitis	
	Scarlet Fever		Ear Infections	
	Measles		Strep Throat	
	Mumps		Rheumatic Fever	
	Rubella		Other:	
	Pertussis			

Has your child ever had any of the following? When, Where, and Results.

Electroencephalograms (EEG):

____

Psychological evaluations:

____

Hearing tests:

____

Speech/language tests:

____

Blood tests:

____

Please bring in any relevant laboratory and imaging results if you have access to them.

Injuries/surgeries/hospitalizations (please list):
____
____

IMMUNIZATIONS

X	Immunization	X	Immunization
	MMR		Tetanus
	DPT		Rubella
	Chicken Pox		Polio
	Measles		H. flu
	Diphtheria		Flu
	Small Pox		Other:
	Mumps		

Adverse reactions: Y N

Is your child hypersensitive or allergic to:

Any drugs? ____

Any foods? ____

Any environmental factors? ______________________________

Breast fed? Yes No If yes, how long? _______

Formula fed? Yes No If yes, milk/soy/other

Typical Food Intake

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Drinks: ____

Water: ____

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

1)_________________________ 5)_________________________

2)_________________________ 6)_________________________

3)_________________________ 7)_________________________

4)_________________________ 8)_________________________

X	Condition	X	Condition	X	Condition	X	Condition
	Mood swings		Acne, boils		Nose bleeds		Frequent urination
	Irritable		Itching		Stuffiness		Bed wetting
	Hyperactivity		Headaches		Hayfever		Belching/ gas
	Introvert		Head injury		Sinus problems		Stomach aches
	Extrovert		Dizziness		Frequent sore throats		Constipation
	Anxiety		High fever		Canker sores		Diarrhea
	Cries easily		Eye pain		Cough		Joint pain
	Unusual fears		Glasses/contacts		Asthma		Muscle spasms
	Sleep issues		Tearing/ dryness		Wheezing		Broken bones
	Nightmares		Earaches		Bronchitis		Anemia
	Heat/cold intolerance		Impaired hearing		Heart disease		Easy bleeding
	Fatigue		Frequent colds		Murmurs		Easy bruising
	Rashes		Eczema		Low blood sugar		High blood sugar

Is there any information about your child's health that you would like to add?

What expectations do you have for your child from working with our clinic?

Welcome and I am honored to work with you and your child!

X______________________________ Date: ________________

Signature