**Pediatric Intake Form**

Patient name: _____ Nick name_____
DOB:_____/_____/_____ Age:_____ Sex: M/F
Address: _____
City, State, Zip: _____
Phone Number (Home): _____-_____-_____ Phone Number (Cell): _____-_____-_____
Preferred Method of Contact: _____ Can the office leave a message? YES / NO

**Emergency Contact:**

Name: _____Relationship:_____

Phone Number (Home): _____-_____-_____ Phone Number (Cell): _____-_____-_____

**Medical Contacts:**

Primary Health Care Provider:_____

Address: _____

Telephone: _____ - _____ - _____

Please list any other health care providers (name, specialty, telephone):

_____

_____

_____

**MEDICAL HISTORY**

Please list your child's health concerns in order of importance:
1. _____
2. _____
3. _____
4. _____

What has your doctor (currently and previously) diagnosed your child with?

_____

_____

_____

Please list known allergies (environmental, food and medications):_____
_____
_____

Please list any and all current medications (prescription and over-the counter) & supplements (vitamins, herbs):

| Name of Drug/ Supplement | Date Started | Dosage/ Frequency | Prescribed for: |
|---|---|---|---|
| | | | |

| | | | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**PREGANCY HISTORY**

Mother's age at child's birth: _____ Mother's first pregnancy: □Y □N If no, # of pregnancies: _____

Please list any medical problems during pregnancy:

_____

_____

Please list any stresses during pregnancy:

_____

_____

Did the mother experience any frights or shocks during the pregnancy? □Y □N

Please describe mother's nutrition during pregnancy?

_____

_____

_____

List medication or supplements taken during pregnancy:

_____

_____

Any exposure to hair dyes, cleaning products, smoke alcohol, marijuana, etc.

_____

_____

Sleep schedule during pregnancy: _____

_____

**BIRTH HISTORY**

Term length: □Full □Premature _____ weeks □Late _____ weeks

Birth weight: _____ lbs. _____ oz. Birth Length: _____

Where was your child born? □Home □Birthing Center □Hospital

_____

Method of delivery: □Vaginal □C-section □Other Intervention □Water Birth

_____

List any complications during labor:

_____

_____

Please list any medical problems during child's newborn period:

_____

_____

How would you describe the personality of your child as an infant?

_____

## NUTRITION AND FEEDING

Was your child breastfed? □Y □N If so for how long? _____

Were there any problems establishing breastfeeding during the newborn period?

□Y □N
If so please describe:
_____

Was formula used: □Y □N If so, at what age? _____

What type? _____

At what age were solid foods introduced? _____

Does your child currently have any feeding/dietary problems? □Y □N
Please specify:
_____

_____

Does your child currently have any dietary restrictions? □Y □N
Please specify:
_____

_____

## DEVELOPMENT

At what age did your child first:
Develop teeth: _____ Run:_____ Sit up: _____ Crawl: _____

Hold head up: _____ Walk: _____ Talk: _____ Smile: _____

Roll over: _____ Toilet Train: _____ Girls only, if menstrual period: _____

Do you have any concerns about developmental delays in your child? □Y □N

If so, please specify

_____
_____
_____

## CHILDHOOD ILLNESSES

□Chicken pox
□Scarlet fever
□Measles
□Mumps
□Tuberculosis

□Pertussis
□Rubella
□Rheumatic fever
□Asthma
□Seasonal Allergies

□Ear Infections
□Strep Throat
□Colds
□Other: _____
_____
_____

Total Ear Infections (in 1 year): _____

Total colds (in 1 year): _____

Total Strep Throats (in 1 year): _____

How many times has your child been treated with antibiotics? _____

## VACCINATION HISTORY

□DPT (diptheria, pertussis, tetanus)
□MMR (measles, mumps, rubella)
□Hepatitis B
□HIB (haemophilus influenze B)

□Polio
□Pneumococcal
□Small pox
□Hepatitis A
□Meningococcal
□RotaVirus

□Varicella (chicken pox)
□Gardasil (HPV)
□Flu shot
□BCG
□Pneumococcal
□Other _____

Did your child ever experience an adverse reaction to a vaccination? □Y □N

If yes, please explain: _____

_____

_____

## ALLERGIES

□Throat clearing
□Hoarseness
□Rashes Where?_____
□Many respiratory infections
□Shortness of Breath
□Complaints of stomach ache between meals
□Behavior change after eating

□Rectal Itch
□Dark/excessive ear wax
□Ear itching
□Frequent ear infections
□Canker sores
□Dark circles under eyes
□Frequent stuffy nose
□Cough

Has your child had food allergy sensitivity test? □Y □N
If so, what were the results?

_____
_____
_____

## LIFESTYLE

EXERCISE:

Does your child spend time outdoors daily? □Y □N

What physical activities does your child participate in?

_____

_____

_____

Hours per day of:

Television: _____ Homework: _____ Computers: _____

Video Games: _____ UTube: _____

Do you have concerns about your child's level of activity? □Y □N

SLEEP:

Where does your child sleep at night? _____ Hours of sleep per night? _____

Please check all that apply:

□ Take naps
□ Nightmares
□ Restlessness
□ Snore
□ Bedwetting
□ Grinds Teeth
□ Insomnia
□ Wakes at night
□ Talks/Yells in sleep

How would you describe your child's energy level? □ Excellent □ Good □ Fair □ Poor

TOLIET HABITS:

Difficulties toilet training? □Y □N Bedwetting? □Y □N History of altering constipation and diarrhea? □Y □N

Bowel movements: How often? _____ Consistency? _____

Color? _____ Mucous? □Y □N Blood? □Y □N

PERSONALITY / MOOD:

How would you describe your child's personality?

_____

_____

_____

Please check all that apply?

□ Oppositional
□ Impulsive
□ Crying spells
□ Feel worthless
□ Hurt self in past
□ Feels like killing self
□ Feels like victim
□Feeling of rage/violence
□ Depression
□ Anxiety
□ Excessive worry
□ Easily angered
□ Nervous
□ Fearful
□ Mood swings
□ Vengeful

□Likes to stay alone for long periods of time
□ Trouble getting along with others
□ Trouble being alone
□ High stressed
□ Apathetic
□ Trouble leaving house
□ Ritualistic behavior
□ Perfectionist

Has your child lost someone close to them either a death or separation? □Y □N

Has your child ever experienced abuse? □Y □N

Has your child ever witnessed violence? □Y □N

**FAMILY HISTORY**

| | Age at Death (if living leave blank) | Health Conditions |
|---|---|---|
| Mother | | |
| Father | | |
| Siblings | | |
| | | |
| | | |
| | | |
| Maternal Grandmother | | |
| Maternal Grandfather | | |
| Paternal Grandmother | | |
| Paternal Grandfather | | |

## REVIEW OF SYSTEMS (check all that apply)

**GENERAL**
□Chills
□Fever
□Dizziness/vertigo
□Light-headedness
□Forgetfulness
□Fatigue
□Hair loss
□Headache
□Nervousness
□Anxiety/depression
□Sweating
□Numbness
□Loss of sleep
□Weight loss or gain

**SKIN**
□Easy bruising
□Hives/itching
□Moles
□Rash
□Scars/keloids
□Sores/ulcers

**GENITO-URINARY**
□Painful urination
□Frequent urination
□Lack of bladder control
□Change in urine odor
□Frequent UTI
□Blood in urine

**CARDIOVASCULAR**
□Arrhythmia/murmur
□Atherosclerosis
□Chest pain
□Palpitations
□Shortness of breath
□High blood pressure
□Low blood pressure
□Cold extremities
□Swelling in hands/feet
□Varicose veins
Other:_____

**GASTROINTESTINAL**
□Poor appetite
□Gas/Bloating/belching
□Foul odor in stool/gas
□Change in bowels
□Constipation
□Diarrhea
□Excessive thirst
□Excessive hunger
□Ingestion/heartburn
□Nausea/vomiting
□Hemorrhoids
□Stomach pain/discomfort
□Blood in stool

**EYE/EAR/NOSE/THROAT**
□Visual floaters
□Increased tearing or dryness
□Blurred/double vision
□Glaucoma/cataract
□Earache
□Ear discharge
□Ringing in the ears
□Hearing loss
□Stuffy or runny nose
□Nosebleeds
□Sinus problems
□Teeth or gum problems
□Dry mouth
□Bleeding gums
□Hoarseness
□Bad breath
□Difficulty swallowing
□Persistent cough
□Tonsil removal

**NEUROLOGIC**
□Loss of coordination
□Seizures/epilepsy
□Fainting
□Paralysis/weakness
□Brain fog/memory difficulties

Why did you choose to come to this office?

_____

_____

_____

What three expectations do you have from this visit?

_____

_____

_____

_____

What expectations do you have of me as your child's health care provider?

_____

_____

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate lifestyle? (Rate from 1 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

What behaviors or lifestyle habits do you currently have in place that you believe **support** your child's health?

_____

_____

_____

_____

What behaviors or lifestyle habits do you currently have in place that **impairs** your child's health?

_____

_____

_____

_____

What **potential obstacles** do you foresee that would interfere with the implementation of changes for your child?

_____

_____

_____

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How do you, as a caregiver, need to be supported to make these beneficial changes for your child?

_____

_____

_____

_____

What does your child LOVE to do?

_____
_____
_____
_____

Thank you for taking the time to fill out this intake!