ProactivePediatric
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? ☐Y ☐N

EMERGENCY CONTACT
Name: _____
Relationship: _____
Phone number: ____-____-____

MEDICAL CONTACTS

Name of PCP: _____
Address: _____
Phone: ____-____-____
Please list any other health care providers (name, specialty, contact info):
_____
_____
_____

MEDICAL HISTORY

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

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 any medication or supplements taken during pregnancy:

_____

_____

_____

_____

Any exposure to hair dyes, cleaning products, smoke, alcohol, marijuana or other toxins during pregnancy? Please specify: _____

_____

_____

Sleep issues during pregnancy? yes/no

BIRTH HISTORY

Term length: □Full □Premature _____ # weeks □Post due date _____ # weeks

Birth weight: _____ lbs. _____ oz. Birth Length: _____ Apgars: _____/____

Where was your child born?

_____

Method of delivery: □Vaginal □C-section □Other Intervention _____

_____

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? _____

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? _____

How did you initiate solid introduction? _____

What foods were introduced first? _____

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

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

What foods does your child crave? _____

What foods does your child refuse? _____

Have you noticed any food reactions? □Y □N If so please explain: _____

_____

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, menstrual period: _____

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

If so, please specify: _____
_____
_____

Common Childhood Conditions

☐Asthma
☐Seasonal allergies
☐Ear infections
☐Eczema/rashes
☐Headaches
☐Stomach aches
☐Strep Throat
☐Impetigo
☐Sinus infections
☐Reflux
☐RSV
☐Pneumonia
☐Bronchitis
☐Colds
☐MRSA
☐TB

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

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: _____

Youtube:_____

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

SLEEP:

Does your child have a sleep routine? □Y □N If so, explain: _____

_____

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

Please check all that apply:

☐ Take naps	☐ Snore/Apnea	☐ Insomnia
☐ Nightmares	☐ Bedwetting	☐ Wakes at night
☐ Restlessness	☐ Grinds Teeth	☐ 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 constipation/ diarrhea? ☐Y ☐N Burning on urination? ☐Y ☐N Crystals noted in diaper/urine? ☐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?

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? _____

ProactivePediatrics
An Integrative Approach

_____

_____

What three expectations do you have from this visit?

1. _____
2. _____
3. _____

What expectations do you have of me? _____

_____

_____

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? _____

_____

_____

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!