



PEDIATRIC INTAKE FORM (Birth- 5 years)

Name _____ Date of first visit _____
 Age _____ Date of Birth _____ Gender: female _____ male _____
 Mother's name _____ Father's name _____
 Address _____ City _____ State _____
 Phone # (home) (_____) _____ Parents work # (_____) _____
 How did you hear about this clinic? _____
 Name of Dr.'s Office/Hospital/Clinic where your child's health records are kept _____

 Reason for referral or presenting problems _____

What are your child's most important health problems? List as many as you can in order of importance.

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Does your child have a contagious disease at this time? Y N
 If yes, what? _____

ALLERGIES

Is your child hypersensitive or allergic to:
 Any drugs? _____
 Any foods? _____
 Anything environmental? _____
 Breast-fed? ____ how long? ____ Formula? ____ milk / soy ____

MEDICATIONS

	Now	Past		Now	Past
Aspirin	_____	_____	Antibiotics	_____	_____
Tylenol	_____	_____	Anti-histamine	_____	_____
Decongestant	_____	_____	Other	_____	_____
Ibuprofen	_____	_____	Allergies to medicines	_____	

MEDICAL HISTORY

_____ Chicken pox	_____ Scarlet fever	_____ Tonsillitis (how often)	_____
_____ Measles	_____ Pneumonia	_____ Ear infections (how often)	_____
_____ Mumps	_____ Frequent colds	_____ other (please list)	_____
_____ Rubella	_____ Rheumatic fever		

Has your child had any of the following tests? When Where Results
 Electroencephalogram.....
 Psychological evaluation.....
 Hearing
 Speech/Language.....
 Injuries/Surgeries/Hospitalizations (please list): _____

IMMUNIZATIONS

____ MMR ____ Polio ____ Hib ____ Smallpox ____ Chicken Pox
 ____ Hep B ____ DPT ____ Tetanus ____ Prevnar
 Others (list) _____
 Any adverse reactions? Y N What ? _____

FAMILY HISTORY

____ Heart disease ____ Diabetes ____ Birth defects
 ____ Hypertension ____ Arthritis ____ Tuberculosis
 ____ Cancer ____ Allergies ____ Mental illness

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications?
 Mother's age at child's birth? _____
 Any known exposure to toxic chemicals or solvents in-utero or after ? _____
 Mother's health during pregnancy?
 ____ Bleeding ____ Physical or emotional trauma
 ____ Nausea ____ Cigarettes, alcohol, drug consumption
 ____ Illnesses ____ Medications
 ____ Hypertension ____ Thyroid problems ____ Diabetes

BIRTH HISTORY

Term: Full _____ Premature _____ Late _____ Weight at birth _____
 Length of labor _____ Complications? _____
 Did your child have any of the following problems shortly after birth?
 ____ Birth defects ____ Birth injuries ____ Blue baby
 ____ Cerebral palsy ____ Seizures ____ Jaundice
 ____ Colic ____ Fever ____ Rashes
 Other (explain) _____
 Child's sleep patterns (first year) _____
 Feeding: Breast-fed? _____ How long? _____ Formula? _____ milk / soy _____
 Age began solids _____ Which foods? _____
 Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

TYPICAL DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

What foods have you found that your child has reactions to?

List any food that your child craves

List any foods that your child greatly dislikes

Is your child thirsty ? Yes No What temperature liquid do they prefer ? _____

How much do they drink daily ? _____

What type of water do you normally use (Please circle)?

Well Spring Distilled Filtered De-ionized Tap

REVIEW OF SYSTEMS

Please check any of the following conditions your child currently has (C box), has had in the past (P box), or has never had (N box). Please also check if you feel any of the following are a significant part of your child's medical history.

LIFESTYLE

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cries easily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unusual fears

ENDOCRINE

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heat or cold intolerance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive hunger
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue

IMMUNE

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic fatigue syndrome
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronically swollen glands
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reactions to vaccines
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High fevers

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic infections
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow wound healing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reactions to immunizations
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

NEUROLOGIC

C P N

			Seizures
			Muscle weakness
			Tremor
			Vertigo or dizziness

C P N

			Heat or cold intolerance
			Numb/Tingling extremities
			Loss of memory
			Difficulty concentrating

C P N

			Hives
			Acne
			Hair loss

SKIN

C P N

			Eczema
			Chronic rash
			Itching

C P N

			Headaches
			Migraines

HEAD

C P N

			Head injury
			Jaw/TMJ problems

C P N

			Impaired hearing
			Earaches

EARS

C P N

			Ringing in the ears/ Tinnitus
			Dizziness/ car sickness

C P N

			Spots in eyes
			Impaired vision
			Blurriness
			Color blindness
			Double vision

EYES

C P N

			Cataracts
			Glasses or contacts
			Eye strain/pain
			Tearing or dryness
			Glaucoma

NOSE & SINUSES

C P N

			Frequent colds
			Stuffiness or post-nasal drip
			Sinus problems

C P N

			Nose bleeds
			Hayfever
			Loss of smell

MOUTH & THROAT

C P N

			Frequent sore throat
			Teeth grinding
			Gum problems/bleeding gums
			Dental cavities

C P N

			Copious saliva
			Sore tongue/lips, canker sores
			Hoarseness
			Jaw clicks

RESPIRATORY

C P N

			Cough
			Spitting up blood
			Asthma
			Pneumonia
			Shortness of breath at night
			Pain on breathing

C P N

			Sputum
			Wheezing
			Bronchitis
			Shortness of breath lying down
			Difficulty breathing
			Shortness of breath

CARDIOVASCULAR/ PERIPHERAL VASCULAR

C P N

			High/low blood pressure
			Blood clots
			Anemia

C P N

			Murmurs
			Fainting
			Easy bruising

GASTROINTESTINAL

C P N

			Trouble swallowing
			Reflux
			Heartburn
			Vomiting blood
			Nausea
			Change in appetite
			Vomiting
			Belching or passing gas

C P N

			Constipation
			Diarrhea
			Blood with stool
			Change in bowel movements
			Abdominal pain or cramps
			No appetite
			Black stools
			Jaundice

URINARY

C P N

			Pain on urination
			Increased frequency
			Frequent infections

C P N

			Frequency at night
			Inability to hold urine/urgency
			Bloody urine

MUSCULOSKELETAL

C P N

			Joint pain or stiffness
			Broken bones
			Muscle spasms or cramps

C P N

			Arthritis
			Weakness
			Flat feet

LIVING ENVIRONMENT

Which of the following do you use routinely in your home :

Forced air	Radiant heat	Air Conditioning	Electric Blanket	Wood Stove
Oil heat	Gas Heat	Electric Heat	Microwave	Television
Computer screen		Cigarettes	Feather Pillow	

Has your child experienced any major grief or loss in their life?

Does your child have any fears? Are they unmanageable?

Thank you. We look forward to helping your child in any way we can.