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PEDIATRIC INTAKE FORM (Birth- 5 years)

Patient's name: _____ Date of first visit: _____

Age: _____ Date of Birth: ____/____/____ Gender: female _____ male _____

Mother's name: _____ Father's name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone # (home): (____) _____ Parents # (work): (____) _____

Parents e-mail address: _____

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: _____

MEDICATIONS

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

MEDICAL HISTORY

_____ Chicken pox	_____ Scarlet fever	_____ Tonsillitis, approx. no.
_____ Measles	_____ Pneumonia	_____ Ear infections, no.
_____ 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

_____ Measles _____ Polio _____ MMR _____ Smallpox _____ Diphtheria

_____ Mumps _____ DPT _____ Tetanus _____ Influenza

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? _____

Mother's health during pregnancy?

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Physical or emotional trauma |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Cigarettes, alcohol, drug consumption |
| <input type="checkbox"/> Illnesses | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thyroid problems |
| | <input type="checkbox"/> 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?

- | | | |
|---|---|------------------------------------|
| <input type="checkbox"/> Birth defects | <input type="checkbox"/> Birth injuries | <input type="checkbox"/> Blue baby |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Seizures | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Fever | <input type="checkbox"/> Rashes |

Other (explain) _____

Child's sleep patterns (first year) _____

Food intolerances (if any) _____

Feeding: Breast fed? _____ how long? _____ Formula? _____ milk / soy _____

Age began solids _____ Which foods? _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS (mark **Y** if current, **P** significant past symptom)

- | | | |
|---|---|--|
| <input type="checkbox"/> Hives | <input type="checkbox"/> Burning of urine | <input type="checkbox"/> Bloody urine |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Cries easily |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Vomiting spells | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Anemia | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> High fevers | <input type="checkbox"/> Stomach aches | <input type="checkbox"/> Sensitive to light |
| <input type="checkbox"/> Chronic rash | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Body/breath odor |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Motion/car sickness |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Flat feet | <input type="checkbox"/> No appetite |
| <input type="checkbox"/> Sore throats | <input type="checkbox"/> Constipation | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Gas | <input type="checkbox"/> Canker sores |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Unusual fears |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Joint pains | <input type="checkbox"/> Excessive fatigue |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Dizzy spells | <input type="checkbox"/> Hair loss |

DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

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