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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	______	_____
Ibuprofin	______	_____	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?

_____ 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) ____

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)

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