Comprehensive Pediatric Intake Form

PERSONAL INFORMATION:

Date of Initial Consultation _____ Child's Full Name _____

Date of Birth _____ Gender (check one) ☐ M ☐ F

Address (include city, state, zip) _____

Mobile Phone _____ Alternative Phone _____

E-Mail _____

Health insurance _____ ID # _____

How did you hear about Blossom? _____

FAMILY INFORMATION:

Parent/Guardian Name(s) _____

Parent/Guardian(s) Occupation _____

Sibling Info (please list name, gender, birth date) _____

_____

_____

DIAGNOSES (and/or explanations given to you about your child):

Date of diagnosis:	Diagnosis:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Other concerns to be addressed:

_____

_____

_____

_____

_____

_____

Describe your child to me, including his/her history. Please be as detailed as possible.

_____

_____

_____

_____
_____
_____
_____
_____

When did you first become concerned about your child? _____
_____
_____

What did you first notice? _____
_____

Was the onset sudden or gradual? _____
Was there any event or illness that you or others think brought on your child's symptoms? _____
_____
_____

Please make notation of any other event, action, etc. that you think may have some bearing/relationship to your child's condition. Again, be as detailed as possible and do not hesitate to mention anything, no matter how small or insignificant, that you believe is related to your child's problem(s): _____
_____
_____
_____
_____
_____
_____

CHILD'S MEDICAL HISTORY:

PRIMARY DOCTOR(S) *please list name, phone number and city/state _____
_____
_____

THERAPIST(S) *please list name, type of therapist (speech, OT, PT, etc.), hrs/wk child saw therapist and phone number, city/state
_____
_____
_____

SPECIALIST(S) *please list name, date of evaluation, phone number and city/state _____
_____
_____
_____

PRENATAL HISTORY

Maternal age at delivery _____ years

Illnesses during pregnancy? _____

_____

Medication(s) during pregnancy? _____

_____

Other complications during pregnancy? _____

Medication(s) during labor and delivery? _____

Complications during labor and delivery? _____

_____

_☐ Vaginal or _☐ C-section delivery? (check one) If C-section, explain why: _____

If vaginal delivery, did you have forceps/vacuum? _____

Full term/premature? (Check one) _☐ Full term _☐ Premature How many weeks was your baby born at? _____ weeks

Complications after delivery? _____

_____

_____

Medications given to child during hospital stay? _____

_____

_____

DIETARY/NUTRITIONAL HISTORY:

Breast-fed? _____ If yes, how long? _____

Bottle-fed? _____ If yes, Brand of formula? _____ Begun at what age?_____ For how long?_____

Foods? Begun at what age? _____ First foods? _____

Whole milk? _____ If yes, begun at what age? _____

Known allergies to food? (Please list): _____

_____

_____

Suspected sensitivities to foods? (Please list): _____

_____

_____

Food cravings? (Please list): _____

_____

_____

_____

Foods my child eats: (Place X under the appropriate heading)

Food	Daily	3 - 5 times/wk	1 - 3times/ wk	Never/rarely	Used to eat a lot but no longer does
Cookies	____	____	____	____	____
Candy	____	____	____	____	____
Sweet foods	____	____	____	____	____

Caffeine (soda, tea, etc.)	____	____	____	____	____
Chocolate	____	____	____	____	____
Milk: Whole	____	____	____	____	____
2 %	____	____	____	____	____
1 %	____	____	____	____	____
Skim	____	____	____	____	____
Cheese	____	____	____	____	____
Ice Cream	____	____	____	____	____
Salty Foods	____	____	____	____	____
Meat	____	____	____	____	____
Pasta	____	____	____	____	____
Bread: White	____	____	____	____	____
Wheat	____	____	____	____	____

Other: _____

Check (X) the most appropriate description below of your child's diet:

_____Mostly baby foods
_____Mostly carbohydrates (bread, pasta, etc.)
_____Mostly dairy (milk, cheese, etc.)
_____Mostly meat
_____Mostly vegetarian (vegetables, fruits, grains, etc.)
_____Other. Describe: _____

Please describe your child's stool pattern (Examples: daily, foul, large, mushy, etc.): _____
_____

Please list the foods and beverages normally consumed by your child for three typical days:

DAY 1
Breakfast: _____
Morning snack(s): _____
Lunch: _____
Afternoon snack(s): _____
Dinner: _____
Beverages: _____
Other: _____

DAY 2
Breakfast: _____

Morning snack(s): _____
Lunch: _____
Afternoon snack(s): _____
Dinner: _____
Beverages: _____
Other: _____

DAY 3
Breakfast: _____
Morning snack(s): _____
Lunch: _____
Afternoon snack(s): _____
Dinner: _____
Beverages: _____
Other: _____

FAMILY HISTORY

List any allergies, major illnesses, genetic diseases, or problems for each of the following family members of your child:

Mother: _____
Father: _____
Siblings: _____
Maternal Grandparents: _____
Paternal Grandparents: _____

SOCIAL HISTORY

Who lives in the home with your child? _____
Are any children in your family adopted? _____
Pets in the house? _____
Caregivers besides parents? _____
List the people most important in your child's life _____
Recent changes, losses, births, deaths, divorce, remarriage or moves? _____
_____
Recent travel? If so, where _____
Child's response to these changes _____
_____
Is your child involved in any sports, music, or other activities? Please describe _____

How does your child interact with other children? _____

With adults? _____

ENVIRONMENTAL HISTORY

Do you, your child, or any family members practice any relaxation/stress management techniques? Please describe _____

CHECK THE APPROPRIATE ANSWERS TO THE FOLLOWING QUESTIONS:

Location of home: ☐ City ☐ Suburban ☐ Wooded ☐ Farm ☐ Other (describe) _____

Water: City/well Purification system: ☐ Yes ☐ No If yes, please describe _____

Do you live near: ☐ Power lines ☐ Woods ☐ Industrial areas ☐ Water?

If you live near water, list type: ☐ Swamp ☐ River ☐ Ocean ☐ Other (describe) _____

Does your home have a lot of: Dust/mold/down or feather items (pillows, upholstery, stuffed animals?) If, so, please give details:

Describe your child's bedroom (Check appropriate response):

Bedding: ☐ Synthetic ☐ Down ☐ Feather? **Mattress cover:** ☐ Yes ☐ No

Type of bed: ☐ Crib ☐ Junior Bed ☐ Adult Bed

Flooring: ☐ Carpet: ☐ Wall-to-wall ☐ area rug? ☐ Wood? ☐ Glued down? ☐ Synthetic pad?

Window treatment: ☐ Shades ☐ Blinds ☐ Thin curtain ☐ Heavy curtain ☐ Valance ☐

Other? If other, describe _____

Other items in room including furniture, toys, stuffed animals _____

Flooring in other rooms: Child's bathroom? _____ Living room? _____

Family room/playroom? _____ Other? _____

Is your child sensitive to or bothered by any of the following? Please check where appropriate and list specific products if any:

☐ Perfumes/cosmetics? ☐ Mold? ☐ Soaps? ☐ Animals (dander)? ☐ Paint?

☐ Cleaning products? ☐ Pollens/grasses? ☐ Detergents? ☐ Gasoline? ☐ Dust?

Which products, specifically? _____

Please list known allergies _____

DEVELOPMENTAL HISTORY

Please list AGE when following skills were mastered and any problems associated with these skills:

First words: _____

Phrases or sentences: _____
Walking: _____
Sitting up: _____
Crawling: _____
Running: _____
Walking up/down stairs without help: _____
Jumping: _____
Learned to pedal: _____
Rode 2-wheel bicycle: _____
Put on clothing: _____

MEDICAL HISTORY

Please list all BLOOD tests (CBC, CMP, ferritin, food sensitivities) that have been performed in the past 2 years: _____

_____

_____

_____

Please list all imaging studies (MRI, CT scan, Ultrasound, colonoscopy) that have been performed in the past 2 years: _____

_____

_____

_____

Please list all other tests (stool cultures, hair analysis) performed in the past 2 years: _____

_____

_____

_____

Major surgeries - Please describe procedure, give date, and result: _____

_____

_____

Major injuries - Please describe, give dates, and results: _____

_____

Illnesses - Please list appropriate dates and any complications:

Ear infections _____
Sinus infections _____
Bronchitis _____
Pneumonia _____
Thrush _____
Yeast Infections _____
Chicken Pox _____

Seizures _____
Measles _____
Mumps _____
Rubella _____
Tuberculosis _____
Mono _____
Other: (Please list): _____

Immunizations: Please indicate date and any reactions for those immunizations that your child has received. If the exact date isn't known, please approximate. Please include any side effects/negative reactions to the vaccine.

Diptheria/Pertussis/Tetanus (DTaP,DPT) _____
H Influenza Type B (Hib) _____
Polio (IPV) _____
Measles/Mumps/Rubella (MMR) _____
Hepatitis b Vaccine _____
Pneumococcal (Prevnar) _____
Chicken Pox (Varivax) _____
Flu Vaccine _____
Other _____

Medications/Supplements:

Please list all past prescription medications and any side effects your child may have experienced _____
_____
_____

Please list all current prescription medications and any side effects your child is/has experienced _____
_____
_____

Please list all past supplements (herbal, vitamins, minerals) and any side effects your child may have experienced _____
_____
_____

Please list all current supplements (herbal, vitamins, minerals) and any side effects your child is/has experienced
_____
_____

Therapies and Diets

Please list all therapies you have used and/or are using _____
_____

Please list all diets you have used and/or are using _____
_____

SIGNS AND SYMPTOMS: Please indicate the severity of the signs/symptoms (mild, moderate, severe) and any unique details

Stimming (repetitive actions or movements) _____
Rocking _____
Head banging _____
Self-mutilation _____
Nail biting _____
Hand/arm biting _____
Nail/skin picking _____
Aggressiveness (hitting, kicking, biting others) _____
Mood swings _____
Irritability/tantrums _____
Fears/Anxiety _____
Hyperactivity _____
Inability to concentrate/focus _____
Fidgeting _____
Impulsiveness _____
Breath holding _____
Dizziness _____
Poor coordination _____
Problems with buttons, ties, snaps _____
Processing issues (visual, motor, language) _____
Sensitive to crowds _____
Memory issues _____
Low self-esteem _____
Fatigue _____
Cold hands/feet _____
Cold intolerance _____
Heat intolerance _____
Recurrent/chronic fevers _____
Flushing _____
Difficulty falling asleep _____
Difficulty staying asleep _____
Night walking _____
Nightmares _____
Difficulty waking _____
Bed wetting _____
Day time wetting/soiling _____
Numbness/tingling in hands/feet _____
Headaches _____
Blinking _____

Tics _____
Eye discharge _____
Dark circles/puffiness under eyes _____
Congestion _____
Dripping nose _____
Sensitivity to light _____
Earaches _____
Ringing in ears _____
Sensitivity to noise _____
Bad breath _____
Nose bleeds _____
Acute sense of smell _____
Sore throats _____
Hoarseness _____
Cough _____
Wheezing _____
Swollen gums _____
Canker sores _____
Dry lips/mouth _____
Diarrhea _____
Constipation _____
Blood/mucous in stool _____
Bloating _____
Passing gas _____
Belching _____
Stomachache _____
Refusal to eat _____
Sensitive to texture of food _____
Difficulty swallowing _____
Food cravings _____
Grinding teeth _____
Muscle cramping _____
Tremors _____
Weakness _____
Eczema _____
Psoriasis _____
Hives _____
Acne _____
Cradle cap _____
Easy bruising _____

Itchy scalp _____
Dry skin _____
Oily skin _____
Pale skin _____
Sensitive to texture of clothes _____
Cracking/peeling hands _____
Cracking/peeling feet _____
Soft nails _____
Ridges/pitting of nails _____
Thickening of nails _____
White spots/lines on nails _____
Brittle nails _____
Strong body odor _____
Strong urine odor _____
Strong stool odor _____
Any OCD (obsessive compulsive) behaviors _____
Reflux _____
Colic _____
Toe walking _____
Please list any other signs or symptoms not mentioned above _____
_____
_____

***Thank you for taking the time to fill out this lengthy intake form! The form helps guide the first visit discussions to pertinent issues your child has and/or is currently experiencing.**

Signature: _____ **Date:** _____

Printed Name: _____