Pediatric Intake Form

Today's Date______________________________
Child's Name ___________________________________ Parent/Guardian Name(s) ______________________________________
Age_____________ Date of Birth _________________________ Gender: Male ____ Female ____
Address ____
Phone (_______)__________________________________ E-Mail____
Insurance Company______________________________ Primary Care Physician____
Emergency Contact ____ Phone____
How did you hear about us?____

HEALTH CONCERNS: (in order of importance)
1.____
2. ____
3. ____

MEDICAL HISTORY:
Allergies (food, medication, environmental) ____
Surgeries (Type)____ When?______________________________________
Hospitalization (Reason)____ When?_____________________________________
Trauma (i.e. accidents, falls, fractured bones, sprains, etc.) Explain____

Please mark either current (C) or past (P) to all that apply:

Conjunctivitis/Eye Infections ____	Eczema/Hives/Rashes ____	Anemia ____	Yeast Infection/Thrush ____
Chicken Pox ____	Measles ____	Mumps ____	Rubella ____
Mononucleosis ____	Ear Infections ____	Sinusitis ____	Chronic Runny Nose ____
Frequent Colds ____	Asthma ____	Pneumonia ____	Allergies/Hay Fever ____
Strep Throat/Tonsillitis ____	Chronic Sore Throats ____	Constipation ____	Colic/Gas/Cramping ____
Frequent Diarrhea ____	Gastric Reflux ____	Headaches ____	Seizures ____
Bed Wetting ____	Heart Problems ____	Depression ____	Anxiety ____
ADD/ADHD ____	Comments: ______________________________________		

FAMILY HISTORY: (Please indicate which relative, if any, has had the following. Include M/P/or both to indicate maternal or paternal side)

Allergies____ Diabetes____
Asthma____ Kidney disease_______________________________________
Cancer____ Heart disease____
Depression______________________________________ ADD/ADHD____
Other mental illness______________________________ Autoimmune disease___________________________________
____ Don't know family medical history

MEDICATIONS: (past and current, include supplements):
____
____

DIET: Does your child have any food sensitivities/intolerances/dietary restrictions? ______________________________________
____

IMMUNIZATION HISTORY: (please indicate those your child *has* received and any reactions):

_____ DTaP (diphtheria, tetanus, pertussis) _____ Td, Tdap _____ MMR (measles, mumps, rubella)

_____ Hemophilus Influenza B (Hib) _____ Flu _____ Pneumococcal (PCV, PPV)

_____ Inactivated Polio (IPV) _____ Hepatitis A (HepA) _____ Hepatitis B (HepB)

_____ Meningococcal _____ Rotavirus _____ Varicella (chicken pox)

_____ Human Papillomavirus (HPV) Reactions: ____

PRENATAL HISTORY:

Were there any complications during the pregnancy (trauma, emotional stress, high blood pressure, diabetes, bleeding, toxemia, hospitalizations, medications taken)? Please explain____
____

How was the labor and delivery? Were there any interventions (i.e. forceps, vacuum, C- section)?____________________________
____

Was your child born: (check one) _____ Pre-term _____ Term _____ Post-Term

NEONATAL/INFANT HISTORY:

Child's weight at birth ____________________________ Child's length at birth ____
How were your child's APGAR scores at birth, if known? ____
Was your child breastfed? ________________ If Yes, for how long? ____
If No, what formula was your child given? ____
Was your child healthy during the neonatal period? _________ If No, please explain _______________________________________
At what age was solid food introduced? ______________________________________

SOCIAL HISTORY:

Does your child attend daycare or school? _____Yes _____ No If Yes, what grade/level are they in?___________________________
How is your child's social and academic performance (both in school and at home)? _______________________________________
Is your child involved in any extra-curricular activities, sports, hobbies? _____ Yes _____ No Describe:___________________________
What does your child enjoy doing in their spare time? ____
Does your child get exercise? _____ Yes _____ No How often/What type? ____
How many hours of sleep per day does your child get on average? ____

Parent/Guardian signature: ____ Date: _________________________________