Pediatric Intake Form

Please take the time to fill out this questionnaire carefully. The information you provide will assist in making appropriate decisions about your child's treatment. All information is treated as confidential unless you grant permission to release it. If you have any questions, please ask. PLEASE PRINT AND COMPLETE.

Patient's Name: ____ **DOB:**_____________________

Street Address: ____

City: _________________________________ **State:**_________ **Zip Code:**_______________ **Sex: M / F**

Mother's Name and Occupation: ____

Father's Name and Occupation: ____

Contact Email: ___________________________________ **Daytime Phone:** ___________________________

Evening Phone: __________________________________ **Work Phone:** ______________________________

Emergency Contact: ____

Parents are (circle): **Married** **Separated** **Divorce** **Other:** _________________________

REFERRED BY: ____

Reason for Office Visit: ____

____

Has your child been seen by any other doctor(s) for this complaint? ____ **Yes** ____ **No** ____ **Past**

Please describe past care for this complaint: ____

____

____

Pediatrician's Name and Phone: ____

____

Last time child had blood work done and what labs: ____

____

Any known allergies to food, drugs, environment, animals, etc: ___________________________________

____

____

List all surgeries and hospitalizations, including date occurred:

1) ______________________________ **4)** ______________________________

2)______________________________ **5)** ______________________________

3)______________________________ **6)** ______________________________

List all medications (from drugstore or prescription) child is on now and dosages if known:

1)______________________________ **4)** ______________________________

2)______________________________ **5)** ______________________________

3)______________________________ **6)** ______________________________

List all supplements child is now taking, and dosages if known:

1)______________________________ **4)** ______________________________

2)______________________________ **5)** ______________________________

3)______________________________ **6)** ______________________________

PREVIOUS MEDICAL HISTORY

YES (Y) indicates the child gets the problem regularly
NO (N) indicates the child never had the problem
PAST (P) indicates the child had the problem in the past, but not recently
Please circle the correct one for your child

Ear infections: Y N P If has had, how frequent per year: ________________

Colds: Y N P If has had, how frequent per year: ________________

Strep Throat: Y N P If has had, how frequent per year: ________________

How many times has your child taken antibiotics: ______________________________

Has your child had any of the following:

Chicken Pox: Y N
Age: _________

Rubella: Y N
Age: _________

Mumps: Y N
Age: ___________

Whooping Cough: Y N
Age: _________

Rubeola: Y N
Age: _________

What medications has the child taken in the past and how often:

1)______________________________ **4)** ______________________________

2)______________________________ **5)** ______________________________

3)______________________________ **6)** ______________________________

Hearing test normal: Y N Not Tested

Vision test normal: Y N Not Tested

Speech Impediments: Y N Past

Learning Impediments: Y N Past

VACCINATION HISTORY

Yes, has had; No, has not; Some, did not finish all shots:

MMR: Yes No Some	**DPT:** Yes No Some	**Hep B:** Yes No Some
Hib: Yes No Some	**Chicken Pox:** Yes No Some	**Polio:** Yes No Some

Others: ____

Any reactions to vaccinations? If so, please explain: ______________________________

____

FAMILY HISTORY

Allergies: Y N P	**Obesity:** Y N P	**Cancer:** Y N P
Tuberculosis: Y N P	**Mental Illness:** Y N P	**Heart Disease:** Y N P

Other diseases in your family: ______________________________

If answers yes to any of the above, please write relationship of family member to child and severity of the disease:

____

MOTHER'S PREGNANCY HISTORY

Age at conception: ____________ **Length of Labor:** ____________ **Vaginal Birth:** Y N

Traumatic Birth: Y N **If yes please explain:** ______________________________

____

____

Fertility Issues or Procedures: ______________________________

Medications during pregnancy: ______________________________

How many ultrasounds during pregnancy: ______________________________

Birth interventions (circle one): Forceps Vacuum Extraction C-Section Induction None

During pregnancy did any of the following occur?

Smoking: Y N **Diabetes: Y N** **Nausea/Vomiting: Y N**

Recreational Drugs: Y N **Emotional Stress: Y N** **Alcohol: Y N**

Preeclampsia: Y N **Coffee: Y N**

Dietary Restrictions during pregnancy: Y N If yes, please explain: __________________________

____

HEALTH HISTORY OF CHILD

Gestational age at birth (weeks at birth): _____________________ Apgar scores: ____________________

Birth Weight: _________________ Birth Length: _______________________

Complications after delivery: Y N If yes, please explain: ____________________________________

____

Location of Birth (circle one): Hospital Birthing Center Home

Child Breastfed: Y N For how long: _________________ When put on formula:______________

What formula was used: ______________________ When was solid food introduced:__________________

When was whole milk introduced:____

Any food cravings: ____

First foods: ____

When did child walk: _________________ Talk: ___________________ Develop teeth: _________________

Jaundice as a baby	**Y N**	**Colic**	**Y N**
Cradle Cap	**Y N**	**Anemia**	**Y N**
Eczema or Psoriases	**Y N**	**Stomach Aches**	**Y N**
Diarrhea	**Y N**	**Asthma**	**Y N**
Constipation	**Y N**	**Warts**	**Y N**
Finicky eating	**Y N**	**Nightmares**	**Y N**
Poor teeth	**Y N**	**Bed-Wetting**	**Y N**
Chronic sniffles	**Y N**	**Excessive Tantrums**	**Y N**
Bad foot odor	**Y N**	**Defiant**	**Y N**
Very sweaty	**Y N**	**Fears/Phobias**	**Y N**
Hyperactivity	**Y N**	**Diaper rash**	**Y N**
Growing pains	**Y N**	**Early Puberty**	**Y N**

SOCIAL HISTORY OF CHILD

Any particular household stressor child has witnessed or gone through:

1)____ 4) ____

2)____ 5) ____

3)____ 6) ____

Names and ages of siblings, if any:

____

____

Pets:

____

Recent travel:

____

Recent life changes:

____ ____

Does your child attend school or daycare? (circle one) Y N
If yes, what grade? ________________
Any concerns about school?

____

Sports/Activities:

____

Please list any concerns you have about your child's social interactions:

____

____

ENVIRONMENTAL EXPOSURE

Has the child ever lived near a refinery, polluted area or in a home with lead paint? If so, what sort of pollution were they exposed to: ____

____

____

Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health? ____

____

Does the child seem particularly sensitive to perfumes, gasoline or other vapors? ____________________

____

Do you spray pesticides, herbicides or other chemicals around your home? _________________________

____

What year was your home/apartment built? ____

Do you have vinyl blinds, and what year were they put in? ______________________________________

TYPICAL DAY'S DIET

Breakfast: ____

____

Lunch: ____

____

Dinner: ____

____

Snacks: ____

____

DIGESTION

How is your child's appetite: __________________________

Does he/she have regular bowel movements: Y N

Any tendency to loose stool or constipation: Y N If yes, describe: ___________________________________

Color of stool: ____

SLEEP ROUTINE

What time does your child go to bed: __________________________

What time does he/she wake: ___________________________________

Any problems with sleep (waking, bed-wetting, nightmares, etc.)

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Does the child take a nap: Y N If so, at what time and for how long: ______________________

COMMENTS, CONCERNS, QUESTIONS

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