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Pediatric Intake Form

Patient Name:_____________________________________ DOB:_______________________
Street Address:____
City: ____________________________ Prov: _________ Postal Code: __________________
Home Phone: ______________________ Work Phone:__________________________
Sex (m/f): ______ Grade of School: _________

Mother's Name and Occupation:____
Father's Name and Occupation:____
Parents are (select): Married Separated Divorced Living Together
Other:

Email address:____
Would you like to receive our newsletter? Yes No
Would you like to receive appointment confirmations for your child via email? Yes No

Reason for Office Visit:____
How did you hear of the clinic?____

Has child been seen by any other doctor(s) for this complaint? Yes No Past
Regular Pediatrician name and city located in:___________________________________
Last time you had blood work done and with what physician:_______________________
____

List All Surgeries & Hospitalizations, including date occurred:

1)______________________________________ 4)___________________________________

2)______________________________________ 5)___________________________________

3)______________________________________ 6)___________________________________

List All medicines (from drugstore or prescription) child is on now:

1)____________________________________ 4)______________________________________

2)____________________________________ 5)______________________________________

3)____________________________________ 6)______________________________________

List all supplements child is taking:

1)______________________________________ 4)___________________________________

2)______________________________________ 5)___________________________________

3)_____________________________________ 6)____________________________________

Any known Allergies to food, drugs, environment, animals:____

<u>Previous Medical History</u>

YES indicates the child gets the problem **regularly**; **NO** indicates the child **never** had the problem; **PAST** indicates the child had the problem in the **past**, **but not recentl**y. Please select the correct one for your child.

Ear Infections: If has had, how many total:____________

Colds: If has had, how many total:____________

Strep Throat: If has had, how many total:____________

How many times has the child taken antibiotics:_____________

What other medicines has the child taken and how often:

1)____________________________________ 3)_____________________________________

2)____________________________________ 4)_____________________________________

Hearing Tests Normal: __________
Vision Tests Normal: __________
Speech Impediments: __________
Learning Impediments: __________

Vaccination History

Please select the answer that best fits:
YES, has had; **NO**, has not; **SOME**, did not finish all shots

MMR:
Hep B:
Chicken Pox:
DPT:
Hib:
Polio:

Other:____

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

____

Family History

Allergies:
Cancer:
Mental Illness:
Diabetes mellitus:
Obesity:
Tuberculosis:
Cardiovascular Disease:

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Mother's Pregnancy History

Age at conception:_____________ **Did she have other children already?** Yes No

Health During Pregnancy

Smoking: **Diabetes:** **Coffee:**
Nausea/Vomiting: **Recreational Drugs:**
Emotional Stress: **Preeclampsia:** **Length of Labor:** _________
Vaginal Birth: **Traumatic Birth:**
If the birth was difficult, please explain:____

____

Health of baby at birth:____

Any Particular household stressors child has witnessed or gone through:

1)____ 2)_________________________________

3)____ 4)_________________________________

Typical Day's Diet

Breakfast:____

Lunch:____

Dinner:____

Snacks:____

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Health History of Child

Child Breastfed: Y N For how long:__________ When put on formula:________

What Formula was used:____________ When was child put on solid food:_________

When did child walk:_________ Talk:__________ Develop Teeth: _____________

Jaundice as baby:	Y	N	Colic:	Y	N
Eczema or Psoriasis:	Y	N	Asthma:	Y	N
Cradle Cap:	Y	N	Anemia:	Y	N
Diarrhea:	Y	N	Warts:	Y	N
Constipation:	Y	N	Nightmares:	Y	N
Finicky Eating:	Y	N	Bed-wetting:	Y	N
Poor Teeth:	Y	N	Tantrums:	Y	N
Chronic Sniffles:	Y	N	Disobedient:	Y	N
Bad Foot Odor:	Y	N	Fears/Phobia:	Y	N
Very Sweaty Baby/Child:	Y	N	Diaper Rash:	Y	N
Hyperactivity:	Y	N	Early Puberty:	Y	N

Toxin Exposure

Has the child ever lived near a refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you 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 at all?

____

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

____

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

____

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