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PEDIATRIC INTAKE FORM (Birth- 5 years)

Name ____________________________________ Date of first visit ____________________
Age__________Date of Birth____________Gender: female __________male _________
Mother's name_____________________ Father's name ___________________________
Address____City_____________________State _______
Phone # (home) (____)_________________________Parents work # (_____)_________________
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 ____
____

What are your child's most important health problems? List as many as you can in order of importance.

1)____
2)____
3)____
4)____

Does your child have a contagious disease at this time? Y N
If yes, what? ____

ALLERGIES

Is your child hypersensitive or allergic to:
Any drugs?____
Any foods? ____
Anything environmental?____
Breast-fed?______how long?______Formula?______milk / soy _____

MEDICATIONS	Now	Past		Now	Past
Aspirin	______	_____	Antibiotics	______	_____
Tylenol	______	_____	Anti-histamine	______	_____
Decongestant	______	_____	Other	______	
Ibuprofen	______	_____	Allergies to medicines __________________		

MEDICAL HISTORY

______Chicken pox	______Scarlet fever	______Tonsillitis (how often)
______Measles	______Pneumonia	______Ear infections (how often) _____________
______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

_____MMR _____Polio _____Hib _____Smallpox _____Chicken Pox
_____Hep B _____DPT _____Tetanus _____Prevnar
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? ___________
Any known exposure to toxic chemicals or solvents in-utero or after ? ___________________
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) ____

Feeding: Breast-fed?_______How long?__________Formula?________________milk / soy _________

Age began solids________________________Which foods? ____

Age began: Sitting__________Crawling___________Walking Talking _________

TYPICAL DIET

Please describe your child's typical daily diet:

Breakfast: ______________________________

Lunch: ______________________________

Dinner: ______________________________

Snacks: ______________________________

To Drink: ______________________________

What foods have you found that your child has reactions to?

____

List any food that your child craves

____

List any foods that your child greatly dislikes

____

Is your child thirsty ? Yes No What temperature liquid do they prefer ? ____________

How much do they drink daily ? __________

What type of water do you normally use (Please circle)?

Well Spring Distilled Filtered De-ionized Tap

REVIEW OF SYSTEMS

Please check any of the following conditions your child currently has (C box), has had in the past (P box), or has never had (N box). Please also check if you feel any of the following are a significant part of your child's medical history.

LIFESTYLE

C	P	N		C	P	N	
			Sleep problems				Nervous
			Cries easily				Night sweats
			Nightmares				Unusual fears

ENDOCRINE

C	P	N		C	P	N	
			Heat or cold intolerance				Excessive hunger
			Excessive thirst				Fatigue

IMMUNE

C	P	N		C	P	N	
			Chronic fatigue syndrome				Chronic infections
			Chronically swollen glands				Slow wound healing
			Reactions to vaccines				Reactions to immunizations
			High fevers				

NEUROLOGIC

C	P	N		C	P	N	
			Seizures				Heat or cold intolerance
			Muscle weakness				Numb/Tingling extremities
			Tremor				Loss of memory
			Vertigo or dizziness				Difficulty concentrating

SKIN

C	P	N		C	P	N	
			Hives				Eczema
			Acne				Chronic rash
			Hair loss				Itching

HEAD

C	P	N		C	P	N	
			Headaches				Head injury
			Migraines				Jaw/TMJ problems

EARS

C	P	N		C	P	N	
			Impaired hearing				Ringing in the ears/ Tinnitus
			Earaches				Dizziness/ car sickness

EYES

C	P	N		C	P	N	
			Spots in eyes				Cataracts
			Impaired vision				Glasses or contacts
			Blurriness				Eye strain/pain
			Color blindness				Tearing or dryness
			Double vision				Glaucoma

NOSE & SINUSES

C	P	N		C	P	N	
			Frequent colds				Nose bleeds
			Stuffiness or post-nasal drip				Hayfever
			Sinus problems				Loss of smell

MOUTH & THROAT

C	P	N		C	P	N	
			Frequent sore throat				Copious saliva
			Teeth grinding				Sore tongue/lips, canker sores
			Gum problems/bleeding gums				Hoarseness
			Dental cavities				Jaw clicks

RESPIRATORY

C	P	N		C	P	N	
			Cough				Sputum
			Spitting up blood				Wheezing
			Asthma				Bronchitis
			Pneumonia				Shortness of breath lying down
			Shortness of breath at night				Difficulty breathing
			Pain on breathing				Shortness of breath

CARDIOVASCULAR/ PERIPHERAL VASCULAR

C	P	N		C	P	N	
			High/low blood pressure				Murmurs
			Blood clots				Fainting
			Anemia				Easy bruising

GASTROINTESTINAL

C	P	N		C	P	N	
			Trouble swallowing				Constipation
			Reflux				Diarrhea
			Heartburn				Blood with stool
			Vomiting blood				Change in bowel movements
			Nausea				Abdominal pain or cramps
			Change in appetite				No appetite
			Vomiting				Black stools
			Belching or passing gas				Jaundice

URINARY

C	P	N		C	P	N	
			Pain on urination				Frequency at night
			Increased frequency				Inability to hold urine/urgency
			Frequent infections				Bloody urine

MUSCULOSKELETAL

C	P	N		C	P	N	
			Joint pain or stiffness				Arthritis
			Broken bones				Weakness
			Muscle spasms or cramps				Flat feet

LIVING ENVIRONMENT

Which of the following do you use routinely in your home :

Forced air Radiant heat Air Conditioning Electric Blanket Wood Stove
Oil heat Gas Heat Electric Heat Microwave Television
Computer screen Cigarettes Feather Pillow

Has your child experienced any major grief or loss in their life?

____

Does your child have any fears? Are they unmanageable?

____

Thank you. We look forward to helping your child in any way we can.