

Pediatric Intake Form

Today's Date ____/____/____

Patient Name _____	DOB _____	Age _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address _____	City _____	State _____	Zip _____

Parent or Guardian Contact Information	
Name _____	Relationship to Child _____
(<input type="checkbox"/> check box if address is same as above)	
Address _____	City _____ State _____ Zip _____
Home Phone _____	Cell or Alternate Phone _____ E-mail _____
Parents are: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law <input type="checkbox"/> Other:	
How did you hear about us?	

Emergency Contact	
Name _____	Relationship to Child _____
Phone _____	Cell or Alternate Phone _____

Pediatrician	
Name _____	Phone _____
Address _____	City _____ State _____ Zip _____

Health Concerns	
Please list health concerns in order from most bothersome to least bothersome. Please include Mental, Emotional, and Physical concerns.	
1) _____	Length of Time _____
2) _____	Length of Time _____
3) _____	Length of Time _____
4) _____	Length of Time _____

Birth History	
<p style="text-align: center;">Prenatal</p> <p>Previous Preg.(#)_____ Previous Births(#) At time of conception: Mother's Age Father's Age Mother's Pregnancy History: Please check all that apply.</p> <p><input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> Anemia <input type="checkbox"/> Preeclampsia</p> <p><input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> Thyroid Condition</p> <p><input type="checkbox"/> Bleeding <input type="checkbox"/> Physical Trauma</p> <p><input type="checkbox"/> Infection <input type="checkbox"/> Emotional Stress</p> <p><input type="checkbox"/> Coffee <input type="checkbox"/> Smoking</p> <p><input type="checkbox"/> Recreational Drugs <input type="checkbox"/> Alcohol</p> <p><input type="checkbox"/> Prescription Medication (please list)</p> <p>Did you take a prenatal vitamin: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p style="text-align: center;">Birth</p> <p>Did baby deliver on time? (If No, + weeks =_____, or – weeks =_____). Length of Labor Vaginal Birth or C-Section Babies birthweight (lbs)_____ Length (in.) Were there any birth complications?</p>

Hospitalizations, Surgeries, and Major Illnesses	Vaccination History										
<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%; padding: 5px;">Condition or Procedure</th> <th style="width: 30%; padding: 5px;">Date</th> </tr> </thead> <tbody> <tr><td style="padding: 5px;">1)</td><td></td></tr> <tr><td style="padding: 5px;">2)</td><td></td></tr> <tr><td style="padding: 5px;">3)</td><td></td></tr> <tr><td style="padding: 5px;">4)</td><td></td></tr> </tbody> </table>	Condition or Procedure	Date	1)		2)		3)		4)		<p>Please check all that apply. <input type="checkbox"/> HepB <input type="checkbox"/> DTP <input type="checkbox"/> Hib <input type="checkbox"/> Polio <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> Other Any reactions or complications from vaccinations?</p>
Condition or Procedure	Date										
1)											
2)											
3)											
4)											

Medications	Supplements
Please list all prescription and over-the-counter medications child is currently taking.	Please list all supplements child is currently taking, including brand names.

Medication	Dosage	Supplement	Dosage
1)		1)	
2)		2)	
3)		3)	
4)		4)	

Health History

Any known allergies to foods, medications, environmental or other allergy? Please describe.

	Now Past	
Now Past		
Now Past		
		<input type="checkbox"/> <input type="checkbox"/>
Asthma		<input type="checkbox"/> <input type="checkbox"/>
		<input type="checkbox"/> <input type="checkbox"/>
Gastric Reflux		<input type="checkbox"/> <input type="checkbox"/>
		<input type="checkbox"/> <input type="checkbox"/>
Chicken Pox		<input type="checkbox"/> <input type="checkbox"/>
		<input type="checkbox"/> <input type="checkbox"/>
Coughing/Wheezing		<input type="checkbox"/> <input type="checkbox"/>
		<input type="checkbox"/> <input type="checkbox"/>
Colic/Gas		<input type="checkbox"/> <input type="checkbox"/>
		<input type="checkbox"/> <input type="checkbox"/>
Mononucleosis		<input type="checkbox"/> <input type="checkbox"/>
		<input type="checkbox"/> <input type="checkbox"/>

Eczema	<input type="checkbox"/>
	<input type="checkbox"/>
Teething Difficulty	<input type="checkbox"/>
	<input type="checkbox"/>
Mumps	<input type="checkbox"/>
	<input type="checkbox"/>
Hives	<input type="checkbox"/>
	<input type="checkbox"/>
Thrush	<input type="checkbox"/>
	<input type="checkbox"/>
Rubella	<input type="checkbox"/>
	<input type="checkbox"/>
Chronic Sniffles/Runny Nose	<input type="checkbox"/>
	<input type="checkbox"/>
Cradle Cap	<input type="checkbox"/>
	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>
	<input type="checkbox"/>
Frequent Colds	<input type="checkbox"/>
	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>
	<input type="checkbox"/>
Whooping Cough	<input type="checkbox"/>
	<input type="checkbox"/>
Strep Throat/Tonsillitis	<input type="checkbox"/>
	<input type="checkbox"/>
Diaper rash	<input type="checkbox"/>
	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>

Anemia	<input type="checkbox"/>
	<input type="checkbox"/>
Stomach Aches	<input type="checkbox"/>
	<input type="checkbox"/>
Dental Cavities	<input type="checkbox"/>
	<input type="checkbox"/>
Cold Sores	<input type="checkbox"/>
	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>
	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/>
	<input type="checkbox"/>
Headaches	<input type="checkbox"/>
	<input type="checkbox"/>
Constipation	<input type="checkbox"/>
	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>
	<input type="checkbox"/>
Ear Infections (# times):	<input type="checkbox"/>
	<input type="checkbox"/>
Bed-wetting	<input type="checkbox"/>
	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>
	<input type="checkbox"/>
Very Sweaty Baby/Child	<input type="checkbox"/>
	<input type="checkbox"/>
Urinary Tract Infxn	<input type="checkbox"/>
	<input type="checkbox"/>

Nightmares

Hearing Test Normal: Yes No Not Tested
Vision Test Normal: Yes No Not Tested

Speech Difficulty: Yes No Past
Learning Difficulty: Yes No Past

How many times has the child taken antibiotics?

General

Was child breastfed?
If yes, for how long? _____ If no, what formula?
When was solid food introduced?

When did the following milestones occur:
Rolling over _____ First tooth _____ Sitting _____ Walking _____
Talking _____ Dressed self _____

Family History

Mother
Father
Siblings
Grandparents

Allergies

Asthma

Eczema

Diabetes

Cancer

Cardiovascular Disease

Obesity

Tuberculosis

Mental Illness

Other: