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Pediatric intake Form

Patient name _____ Date of Birth_____Age _____

Parent/Guardian name/s _____Phone number _____

Address _____

Child's primary care provider _____ Phone number _____

Reasons for your visit _____

_____

Pregnancy and birth

Place of birth_____

Child is yours by: (circle one) birth/adoption/stepchild/other

Please note any medical problems associated with pregnancy, including fertility Issues.

_____

_____

Describe any interventions at birth including caesarean section.

_____

Gestational age at birth:_____Birth weight:_____ Birth length: _____

Location of birth: (circle one) home / hospital / birthing center

Health issues during newborn period _____

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Diet

Child breast fed: (circle one) Y N If yes, how long?_____
When was solid food introduced?
_____
First food introduced: _____
Adverse reactions noted: _____

Any known food sensitivities _____
_____

Vaccinations History

MMR Y N Age: _____ DPT Y N Age: _____ Hib Y N Age: _____
Hep B Y N Age: _____ Chicken Pox Y N Age: _____ Polio Y N Age: _____
Others: _____
Adverse reactions to vaccines: _____

Social History

Are both parents living in the home? Y N
Names and ages of siblings, if any: _____
_____
_____
Recent travel: _____
Recent life changes: _____
Does your child attend school/Day care? (circle one) Y N If yes, what grade? _____

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Any concerns about school? _____

Sports, activities: _____

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

_____

Medical History

Past and current medications: _____

Supplements: _____

Illnesses: _____

Surgeries or other trauma: _____

Typical diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

Please circle any of the conditions listed below that are a concern for your child:

Appetite: poor / excessive
Headaches
Thirst: little / excessive
Poor concentration
Unusual sweating
Frequent colds
Asthma
Energy level: low / excessive
Sleep: poor / excessive sleepiness / night terrors
Bowel movements: constipation / loose stools / diarrhea
Digestion: vomiting/reflux/abdominal pain
Urination: frequent / painful / bedwetting
Seizure

Skin problems: Specify: _____
Allergies: _____
Emotional problems: _____
Other: _____