PEDIATRIC INTAKE FORM (BIRTH TO 5 YEARS)

Patient's Name:_____ Date: _______________

Age: _____ Date of Birth: _____________ Gender: Female / Male

Parent/Guardian's Name: _____

Address: _____

City: _____State: _____ Zip: _____

Telephone (home): _____ (Parent's work): _____

Parent's email address: _____

How did you hear about this clinic? _____

Has any other family member already been a patient at this clinic? _____

Name of doctor's office/hospital/clinic where your child's health records are kept:

_____

Reason for referral or presenting problems:

_____

MEDICATIONS

NOW PAST NOW PAST
____ Aspirin ____ Decongestants
____ Tylenol ____ Anti-histamine
____ Antibiotics ____ Other
____ Ibuprofen
Allergies to medicines: _____

MEDICAL HISTORY
_____Chicken pox _____ Scarlet fever _____ Tonsillitis, approx no. of times: _____
____ Measles Pneumonia Ear infections, approx no. of times: _____
____ Mumps Frequent colds Strep throat, approx no. of times: _____
____ Rubella Rheumatic fever Other: _____

Has your child ever had any of the following? WHEN WHERE RESULTS
____ Electroencephalogram (EEG):
____ Psychological evaluations:
____ Hearing test:
____ Speech/language tests:
____ Injuries/surgeries/hospitalizations (please list):

IMMUNIZATIONS
_____ MMR _____ DPT _____ Chicken pox _____ Others:
____ Measles _____Diphtheria ____Small pox _____ Adverse reactions: Y / N If so, what?
____ Mumps _____ Tetanus _____ H. influenza _____ Adverse Reactions: Y/N If so, what?
____ Rubella _____ Polio _____ The Flu Shot _____ Adverse Reactions: Y/N If so, what?

FAMILY HISTORY

____Heart disease _____ Diabetes ____ Birth defects
____Hypertension ____Arthritis ____Tuberculosis
____Cancer ____ Allergies ____ Asthma
____ Mental illness _____ Osteoporosis _____Other significant:

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications? _____
Mother's age at child's birth: _____
Mother's health during pregnancy: _____
Did Mother experience any of the following during pregnancy: _____Bleeding _____Nausea
_____ Physical or emotional trauma _____Other:
_____Illnesses _____Hypertension _____Cigarettes, alcohol, drug consumption
_____Medications: _____
_____Diabetes _____Thyroid problems

BIRTH HISTORY

Term (circle): Full Premature Late Length of labor: _____
Complications: _____ Other: _____

Did your child have any of the following problems shortly after birth?
_____ Rashes _____Birth injuries _____Blue baby
_____ Jaundice _____Seizures _____Cerebral palsy
_____ Colic _____ Fever _____Birth defects

Child's sleep patterns (1st year): _____
Food intolerances: _____
Breast fed: Y / N How long: _____ Formula: Y / N Type (milk, soy):
Age began solids: _____Which foods: _____
Age began: Sitting _____Crawling _____Walking _____Talking _____

SYMPTOMS Circle if your child has experienced any of the following:

Hives	Burning urine	Bloody urine	Eczema
Cries easily	Bleeding gums	Heart murmur	Nervous
Nose bleeds	Vomiting spells	Sleep problems	Asthma
Acne	Anemia	Night sweats	High fevers
Jaundice	Sensitive to light	Chronic rash	Stomach aches
Diarrhea	Hearing loss	Easy bruising	Sore throats
Flat feet	No appetite	Body/breath odor	Constipation
Nightmares	Frequent colds	Bleeding tendency	Unusual fears
Wheezing	Joint pains	Excessive fatigue	Cough
Dizzy spells	Hair loss	Frequent urination	Allergies

DIET

Please describe your child's typical daily diet:
Breakfast:
Lunch:
Dinner:
Snacks:
To drink:

THANK YOU. WE LOOK FORWARD TO HELPING YOUR CHILD IN ANY WAY WE CAN.