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Pediatric Intake Form

Child's Name: _____ Birth date: _____ Age: _____

1st Parent's Name: _____ Age: ____ Occupation: _____

2nd Parent's Name: _____ Age: ____ Occupation: _____

Parent's Marital Status: Married/Partnered Separated Divorced Widowed Other

Siblings Names and Ages: _____

School and Grade: _____

Current Physician: _____

Please remember this is a confidential report. Your honest evaluation is both pertinent and necessary to better enable the doctor to accurately assess the health of your child and effectively work with you to improve your child's general wellbeing.

I: **Current Information**:
Main health problem (when did it start, describe the course of symptoms, what treatment have you tried):
_____
_____
_____

Is your child currently taking any medication? ❑ Yes ❑ No
If so, what medicine and for what condition _____
_____

Is there anything that you would like to discuss without your child present? Describe:
_____

II: **Pregnancy:** Please check any area that applied to the <u>child's mother</u> before/during her pregnancy:

- ❑ Child adopted
- ❑ Fertility treatments/IVF
- ❑ Recreational drug use
- ❑ Smoking
- ❑ Alcohol
- ❑ Caffeine: cola,coffee,teas,chocolate,etc
- ❑ Medications
- ❑ Daily vitamins/minerals
- ❑ Immunization during pregnancy
- ❑ Regular prenatal care
- ❑ Attitude-Happy (majority of time)
- ❑ Attitude-Depressed
- ❑ Complications in pregnancy
- ❑ Any diagnosed illnesses
- ❑ Hospitalization
- ❑ Forced bed-rest
- ❑ Excessive decrease in weight
- ❑ Excessive increase in weight
- ❑ HIV/AIDS
- ❑ Allergic reactions
- ❑ Nausea/vomiting
- ❑ Physical injury
- ❑ Mental trauma
- ❑ Toxic exposure
- ❑ Premature contractions
- ❑ Bleeding
- ❑ Carried to full term

Mother's age at child's conception: _____

III: **Labor and Delivery:**

❑ Home birth ❑ Greater than 12 hours ❑ Medications
❑ Hospital birth ❑ Complications ❑ Forceps
❑ Birthing center ❑ Fetal monitor used ❑ Cesarean
❑ Premature delivery ❑ Other – please explain: _____

IV: **Newborn History**:

Pregnancy Duration (weeks)_____ Birth length_____ Birth weight_____

Please check any of the following areas your child had problems with at or after birth:

❑ Breathing ❑ Coloring ❑ Crying ❑ Nursing
❑ Sleeping ❑ Jaundice ❑ Choking ❑ Failure to thrive
❑ Other: _____

Breast Fed ❑ Yes ❑ No For how long? _____
Bottle Fed ❑ Yes ❑ No For how long? _____ Type of Formula_____
History of colic? ❑ Yes ❑ No Normal Weight Gain? ❑ Yes ❑ No
At what age were solid food introduced?_____ What foods initially?_____

V: **Immunizations:**

Please check all immunizations your child has received, at what age, and reactions, if any:

❑ Diphtheria – age/reaction:_____ ❑ Mumps - age/reaction _____
_____ _____
❑ Pertussis – age/reaction:_____ ❑ Rubella - age/reaction _____
_____ _____
❑ Tetanus – age/reaction:_____ ❑ Chickenpox- age/reaction _____
_____ _____
❑ Polio - age/reaction:_____ ❑ Hep B - age/reaction _____
_____ _____
❑ HIB – age/reaction:_____ ❑ Flu - age/reaction_____
_____ _____
❑ Measles – age/reaction:_____ ❑ Pneumococcus - age/reaction_____
_____ _____

VI: **Hospitalizations and Illnesses:**

Has your child ever been hospitalized or operated on? ❑ Yes ❑ No
Explain: _____
_____

Has child ever had a serious accident (broken bones, head injuries, falls, burns, poisoning)? ❑ Yes ❑ No
Explain: _____
_____

Has your child ever had any of the following illnesses:

❑ Asthma ❑ TB ❑ Chickenpox ❑ Liver disease
❑ Hay fever ❑ Polio ❑ Rheumatic fever ❑ Sickle cell disease
❑ Bronchitis ❑ Diphtheria ❑ Heart/blood vessel disease ❑ Epilepsy/Seizures
❑ Pneumonia ❑ Measles ❑ Bleeding tendencies ❑ Diabetes
❑ Whooping cough ❑ Mumps ❑ Other: _____

Does your child have any allergy problems (rash, itching, swelling, difficulty breathing, sneezing, etc)
a) When eating food? ❑ Yes ❑ No What foods? _____
How does the child react? _____
b) When taking medication? ❑ Yes ❑ No What medicine?_____
How does the child react? _____
c) When near animals, furs, insects, dust, etc? ❑ Yes ❑ No What things? _____
How does the child react? _____
d) At certain times of year? ❑ Yes ❑ No When? _____
How does the child react? _____

VII **General: (**Please check all that apply)

❑ Poor appetite	❑ Cold hands	❑ Insomnia/sleep problems	❑ Weakness
❑ Excess appetite	❑ Cold feet	❑ Heavy sleeper	❑ Poor coordination
❑ Change in appetite	❑ Chills	❑ Wakes in a foul mood	❑ Vertigo/dizziness
❑ Food cravings	❑ Fever	❑ Irregular naps	❑ Fatigue
❑ Nail biting	❑ Sweats easily	❑ Night sweats	❑ Snores while sleeping

❑ Sudden energy drops-at what time? _____
❑ Bleed or bruise easily-where? _____
What time does child usually go to sleep at night? _____ What time does child usually wake? ____
Does child nap? ❑ Yes ❑ No When? _____

VIII **Skin and Hair:** (Please check all that apply)

❑ Rashes	❑ Ulcerations	❑ Psoriasis	❑ Itching
❑ Eczema	❑ Pimples/Acne	❑ Hives	❑ Moles/warts
❑ Change in hair/skin texture		❑ Other hair or skin problems_____	

Complexion: ❑ Pallor ❑ Sallow ❑ Fair ❑ Dark ❑ Ruddy

IX **Head, Eyes, Ears, Nose, and Mouth:** (Please check all that apply)

❑ Dizziness	❑ Spots in eyes	❑ Ringing in ears	❑ Grinding teeth
❑ Concussions	❑ Poor vision	❑ Poor hearing	❑ Cavities/fillings
❑ Facial pain	❑ Blurry vision	❑ Nose bleeds	❑ Braces/orthodonture
❑ Eye strain	❑ Dark circles under eyes	❑ Snotty/Runny nose	❑ Canker sores
❑ Color blindness	❑ Corrective lenses	❑ Nasal congestion	❑ Sores on lips or tongue
❑ Night blindness	❑ Earaches	❑ Sinus problems	❑ Recurrent sore throats
❑ Eye pain	❑ Ear infections	❑ Teeth problems	❑ Ear tubes

❑ Headaches – where and when?_____
_____
❑ Other head or neck problems?_____

X **Respiratory:** (Please check all that apply)

❑ Cough	❑ Coughing blood	❑ Tight chest	❑ Wheezing/Asthma
❑ Difficulty in breathing when lying down		❑ Frequent or recurrent colds/flu	
❑ Production of phlegm – color?_____		❑ Other lung problems:_____	

XI **Gastrointestinal:** (Please check all that apply)

❑ Nausea	❑ Sensitive abdomen	❑ Bloody stools	❑ Rectal pain
❑ Vomiting	❑ Pain or cramps	❑ Black stools	❑ Hemorrhoids
❑ Belching	❑ Excess Gas	❑ Constipation	❑ Anal itching
❑ Bad breath	❑ Diarrhea	❑ Laxative use: _____/week; Type: _____	

❑ Other intestinal problems: _____
Bowel Movements: Frequency: _____Color: _____Odor: _____Texture/Form_____

XII **Genito-Urinary: (**Please check all that apply)

❑ Pain on urination ❑ Frequent urination ❑ Blood in urine ❑ Urgency to urinate
❑ Unable to hold urine ❑ Bedwetting ❑ Wakes to urinate-How often_____/night
❑ Urinary tract infections ❑ Vaginal infections
❑ Discharge from vagina or penis ❑ Early sexual development
❑ Other urinary or genital problems: _____
_____

XIII. **Musculoskeletal: (**Please check all that apply)

❑ Neck pain ❑ Back pain – Where? _____
❑ Muscle cramps ❑ Joint pains – Where? _____
❑ Sprains/Strains ❑ "Growing" pains ❑ Shin splints ❑ Excessively ticklish
❑ Other joint or bone problems: _____

XIV. **Neuro-psychological: (**Please check all that apply)

❑ Fidgety (hands and feet) ❑ Impatient ❑ Difficulty completing tasks
❑ Easily stressed/anxious ❑ Seizures ❑ Trouble with reading/Concentrating
❑ Bad temper ❑ Social difficulties ❑ Learning disabilities
❑ Hyperactive ❑ Nightmares/terrors ❑ Sleepwalks
Predominant emotion/mood: ❑ Angry ❑ Sad ❑ Worried ❑ Happy ❑ Shy ❑ Fearful ❑ Depressed
❑ Treated for emotional problems – describe: _____
❑ Other neurological or psychological problems: _____
_____

Please describe any emotional stresses, shocks, or traumas your child may have experienced: _____
_____
_____

Please describe your child's living situation: _____
_____

XV: **Family Medical History**: If any blood relative to your child have or have had any of the following illnesses, please check accordingly: M (Mother), F (Father), S (Sibling), PGM (Paternal Grandmother), PGF (Paternal Grandfather), MGM (Maternal Grandmother), MGF (Maternal Grandfather)

M	**F**	**S**	**PGM**	**PGF**	**MGM**	**MGF**	
❑	❑	❑	❑	❑	❑	❑	Allergy, asthma, or eczema
❑	❑	❑	❑	❑	❑	❑	Auto-immune disease
❑	❑	❑	❑	❑	❑	❑	Cancer
❑	❑	❑	❑	❑	❑	❑	Diabetes or low blood sugar
❑	❑	❑	❑	❑	❑	❑	Heart trouble
❑	❑	❑	❑	❑	❑	❑	High blood pressure/Stroke
❑	❑	❑	❑	❑	❑	❑	Kidney disease
❑	❑	❑	❑	❑	❑	❑	Liver disease
❑	❑	❑	❑	❑	❑	❑	Tuberculosis
❑	❑	❑	❑	❑	❑	❑	Thyroid problems
❑	❑	❑	❑	❑	❑	❑	Neurological conditions
❑	❑	❑	❑	❑	❑	❑	Mental illness/Nervous disorder
❑	❑	❑	❑	❑	❑	❑	Alcoholism/Addiction
❑	❑	❑	❑	❑	❑	❑	Other: _____

XVI. **Diet/Nutrition:**

What are your child's three favorite foods? _____

_____

What are the three healthiest foods your child eats during an average week? _____

_____

What are the three worst foods that your child eats during an average week?_____

_____

Dietary habits (Please check all that apply):

D=Daily F=Frequently O=Occasionally R=Rarely N=Never

D	F	O	R	N	
❑	❑	❑	❑	❑	Fresh Fruits
❑	❑	❑	❑	❑	Fresh Vegetables
❑	❑	❑	❑	❑	Raw Foods
❑	❑	❑	❑	❑	Sprouted Foods
❑	❑	❑	❑	❑	Whole Grains
❑	❑	❑	❑	❑	Unrefined cereals
❑	❑	❑	❑	❑	Legumes/Beans
❑	❑	❑	❑	❑	Nuts/Seeds
❑	❑	❑	❑	❑	Dairy Products
❑	❑	❑	❑	❑	Peanut Butter
❑	❑	❑	❑	❑	Honey/Molasses
❑	❑	❑	❑	❑	Fruit Juices
❑	❑	❑	❑	❑	Soy Products
❑	❑	❑	❑	❑	Eggs
❑	❑	❑	❑	❑	Fish
❑	❑	❑	❑	❑	Fowl
❑	❑	❑	❑	❑	Red meat
❑	❑	❑	❑	❑	Hot dogs/Cold cuts
❑	❑	❑	❑	❑	White Flour Products (Bread, bagels, crackers, pasta)
❑	❑	❑	❑	❑	White Sugar Products
❑	❑	❑	❑	❑	Artificial Sweeteners
❑	❑	❑	❑	❑	Artificial Colors
❑	❑	❑	❑	❑	Fried Foods
❑	❑	❑	❑	❑	Fast Food
❑	❑	❑	❑	❑	Pre-Packaged Foods
❑	❑	❑	❑	❑	Soda Pop
❑	❑	❑	❑	❑	Chocolate
❑	❑	❑	❑	❑	Candy/Sweets/Desserts

List herb, vitamin & mineral supplements your child is currently taking: _____

_____

_____

_____

Is there anything else that you would like to share about your child?