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PEDIATRIC INTAKE FORM (BIRTH TO 5 YEARS)

Patient's Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Parent's Name's: _____
Telephone (home): _____ (Parent's work): _____
Patient's Age: _____ Date of Birth: _____ Gender: Female / Male
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: _____
_____
Name of Pediatrician_____ Phone_____
Reason for Visit Today: _____
_____
_____

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
____ Mumps ____ Tetanus ____ H. influenza If so, what? _____
____ Rubella ____ Polio ____ The flu _____

FAMILY HISTORY

____ Heart disease ____ Diabetes ____ Birth defects ____ Mental illness ____ Cancer
____ Hypertension ____ Arthritis ____ Tuberculosis ____ Osteoporosis ____ Asthma
____ Allergies Other significant: _____

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications? _____

_____

_____

Mother's age at child's birth: _____

Mother's health during pregnancy:

____ Bleeding ____ Nausea ____ Physical or emotional trauma

____ Illnesses ____ Hypertension ____ Cigarettes, alcohol, drug consumption

____ Medications ____ Diabetes ____ Thyroid problems Other_____

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?

____ Rashes ____ Birth injuries ____ Blue baby

____ Jaundice ____ Seizures ____ Cerebral palsy

____ Colic ____ Fever ____ Birth defects

____ Other: _____

_____

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

____ Hives	____ Burning urine	____ Bloody uring	____ 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. I LOOK FORWARD TO HELPING YOUR CHILD IN ANY WAY I CAN.