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Pediatric Intake Form

Name____ Date _________________________

Age _______ Date of Birth__________________ Female ________ Male _________

Mother's Name_____________________________ Father's Name____________________________

Address ____

City ____________________ State_______ Zip___________

Phone (Home) ___________________________ (Work) ____________________________________

How did you hear about this clinic?____

PLEASE FILL OUT BOTH SIDES OF EACH PAGE

Health History Questionnaire

What are you child's most important health problems?
List as many as you can in order of importance.

1) ____
2) ____
3) ____
4) ____

Does your child have a contagious disease at this time?_______ If yes, what?_________________
____

Previous Illnesses:

Rheumatic fever	Y	German measles	Y
Chicken Pox	Y	Measles	Y
Tonsilitis	Y	Approx. Number_____	
Ear infections	Y	Approx. Number_____	
Other?	Y	List_________________	

Has your child had any of the following tests? When? Where?

Electroencephalogram
Psychological evaluation
Hearing tests
Speech/language tests

Hospitalizations/Surgeries/Injuries

What hospitalizations, surgeries or injuries has your child had?________________________________

____

Polio	Y	Pertussis	Y
Tetanus shot	Y	Diptheria	Y
Measles/Mumps/Rubella	Y	Influenza	Y
Any adverse reactions?	Y	What?	___________________

Allergies

Is your child hypersensitive or allergic to:

Any drugs?____

Any foods?____

Breast fed? _________ How long? __________ Formula? ___________ Milk/soy __________

Typical Food Intake

Breakfast ____

Lunch ____

Dinner ____

Snacks ____

Drinks ____

Please list any prescription medications, over the counter medications, vitamins, or other supplements your child is taking.

1) __________________________________ 2) ____

3) __________________________________ 4) ____

5) __________________________________ 6) ____

Preview of Systems

Y= Present condition **P**=Condition in past

Emotional

Mood swings	Y	P	Anxiety or nervousness	Y	P
Cries easily	Y	P	Unusual fears	Y	P
Sleep problems	Y	P	Nightmares	Y	P
Motion/car sickness	Y	P			

Endocrine

Heat or cold intolerance	Y	P	Fatigue	Y	P
Excessive thirst	Y	P	Excessive hunger	Y	P
Hypoglycemia	Y	P			

Skin

Rashes	Y	P	Eczema, hives	Y	P
Acne, boils	Y	P	Itching	Y	P

Head

Headaches	Y	P	Head injury	Y	P
Dizzy spells	Y	P	High fevers	Y	P

Eyes

Glasses or contacts	Y	P	Tearing or dryness	Y	P
Eye pain/strain	Y	P			

Nose & Sinuses

Frequent colds	Y	P	Nose bleeds	Y	P
Stuffiness	Y	P	Hayfever	Y	P
Sinus problems	Y	P			

Mouth & Throat

Frequent sore throat	Y	P	Canker sores	Y	P
Breath odor	Y	P			

Respiratory

Cough	Y	P	Wheezing	Y	P
Asthma	Y	P	Bronchitis	Y	P

Cardiovascular

Heart disease	Y	P	Murmurs	Y	P

Urinary

Frequent urination	Y	P	Bed wetting	Y	P

Gastrointestinal

Belching or passing gas	Y	P	Stomach aches	Y	P
Constipation	Y	P	Diarrhea	Y	P
Bowel movements	Y	P	How often?_________		

Musculoskeletal

Joint pain or stiffness	Y	P	Broken bones	Y	P
Muscle spasms/ cramps	Y	P			

Blood/Peripheral Vascular

Easy bleeding/ bruising	Y	P	Anemia	Y	P

Is there any information about your child's health that you would like to add?_________________

____

____

Welcome, we are glad to help your child!

Your appointment time has been reserved especially for your child. If you cannot keep your appointment, please give 48 hours notice or you will be charged $75 for the time allocated.

I have read the above and understand my responsibilities.

____ ___________________________

Signature of parent or guardian **Date**