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PEDIATRIC INTAKE FORM (Birth- 5 years)

Patient's name: _____ Date of first visit: _____

Age: _____ Date of Birth: _____/_____/_____ Gender: female _____ male _____

Mother's name:_____ Father's name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone # (home): (_____)_____ Parents # (Cell): (_____)_____

Parents e-mail address: _____

How did you hear about this clinic? _____

Name of Dr.'s Office/Hospital/Clinic where your child's health records are kept: _____

_____

Reason for referral or presenting problems: _____

_____

MEDICATIONS	Now	Past		Now	Past
Aspirin	_____	_____	Antibiotics	_____	_____
Tylenol	_____	_____	Anti-histamine	_____	_____
Decongestant	_____	_____	Other	_____	_____
Ibuprofin	_____	_____	Allergies to medicines _____		

MEDICAL HISTORY

_____ Chicken pox _____ Scarlet fever _____ Tonsillitis, approx. no. _____
_____ Measles _____ Pneumonia _____ Ear infections, no. _____
_____ Mumps _____ Frequent colds _____ other (please list) _____
_____ Rubella _____ Rheumatic fever

Has your child had any of the following tests?	When	Where	Results
Electroencephalogram	.....	.....	.....
Psychological evaluation	.....	.....	.....
Hearing	.....	.....	.....
Speech/Language	.....	.....	.....

Injuries/Surgeries/Hospitalizations (please list): _____

_____

IMMUNIZATIONS

_____ Measles _____ Polio _____ MMR _____ Smallpox _____ Diphtheria
_____ Mumps _____ DPT _____ Tetanus _____ Influenza
Others (list) _____

Any adverse reactions? Y N What ? _____

FAMILY HISTORY

_____ Heart disease _____ Diabetes _____ Birth defects
_____ Hypertension _____ Arthritis _____ Tuberculosis
_____ Cancer _____ Allergies _____ Mental illness

PRENATAL HISTORY

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

_____

Mother's age at child's birth? _____

Mother's health during pregnancy?

_____ Bleeding _____ Physical or emotional trauma

_____ Nausea _____ Cigarettes, alcohol, drug consumption

_____ Illnesses _____ Medications

_____ Hypertension _____ Thyroid problems _____ Diabetes

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?

_____ Birth defects _____ Birth injuries _____ Blue baby

_____ Cerebral palsy _____ Seizures _____ Jaundice

_____ Colic _____ Fever _____ Rashes

Other (explain) _____

Child's sleep patterns (first year) _____

Food intolerances (if any) _____

Feeding: Breast fed? _____ how long? _____ Formula? _____ milk / soy _____

Age began solids _____ Which foods? _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS (mark **Y** if current, **P** significant past symptom)

_____ Hives _____ Burning of urine _____ Bloody urine

_____ Eczema _____ Frequent urination _____ Cries easily

_____ Bleeding gums _____ Heart murmur _____ Nervous

_____ Nose bleeds _____ Vomiting spells _____ Sleep problems

_____ Acne _____ Anemia _____ Night sweats

_____ High fevers _____ Stomach aches _____ Sensitive to light

_____ Chronic rash _____ Jaundice _____ Body/breath odor

_____ Hearing loss _____ Easy bruising _____ Motion/car sickness

_____ Diarrhea _____ Flat feet _____ No appetite

_____ Sore throats _____ Constipation _____ Nightmares

_____ Headaches _____ Gas _____ Canker sores

_____ Frequent colds _____ Bleeding tendency _____ Unusual fears

_____ Wheezing _____ Joint pains _____ Excessive fatigue

_____ Cough _____ Dizzy spells _____ Hair loss

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.