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PEDIATRIC INTAKE FORM (6-12 years)

Name: _____ Date: _____

Age: ____ Date of Birth: _____/_____/_____ Female: _____ Male: _____

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

Address: _____

City: _____ State: _____ Zip Code: _____

Phone # (home): (_____)_____ Parent's # (Cell): (_____)_____

Parent's e-mail address: _____

How did you hear about our clinic? _____

HEALTH HISTORY QUESTIONNAIRE

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

1. _____
2. _____
3. _____
4. _____
5. _____

Does your child have a contagious disease at this time? Y N
If yes, what? _____

Previous Illnesses

Rheumatic fever	Y N	German measles	Y N
Chicken pox	Y N	Measles	Y N
Tonsillitis	Y N	approx. number	_____
Ear infections	Y N	approx. number	_____
Other	Y N	list	_____

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

Electroencephalogram (EEG)

.....

Psychological evaluation

.....

Hearing tests

.....

Speech/Language tests

.....

Hospitalizations/ Surgeries/ Injuries

What hospitalizations, surgeries or injuries has your child had?

_____

_____

Immunizations

Polio	Y N	Pertussis	Y N
Tetanus shot	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Influenza	Y N
Any adverse reactions?	Y N	If yes, what ? _____	

Allergies

Is your child hypersensitive or allergic to:

Any drugs?_____

Any foods? _____

Any environmentals?_____

Breast fed? _____ how long? _____ Formula? ____ milk / soy ____

Typical Food Intake

Breakfast:_____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

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

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

REVIEW OF SYSTEMS

Y = a condition now **P** = significant problem in the past **N** = never had

MENTAL/ EMOTIONAL

Mood Swings	Y P N		Anxiety/nervousness	Y P N	
Irritability	Y P N		Cries easily	Y P N	
Hyperactivity	Y P N		Unusual fears	Y P N	
Introvert/extrovert	Y P N		Sleep problems	Y P N	
Motion/car sickness	Y P N		Nightmares	Y P N	

ENDOCRINE

Heat/cold intolerance	Y P N		Fatigue	Y P N	
Excessive thirst	Y P N		Excessive hunger	Y P N	
Low blood sugar	Y P N		High blood sugar	Y P N	

SKIN

Rashes	Y P N		Eczema, Hives	Y P N	
Acne, Boils	Y P N		Itching	Y P N	

HEAD

Headaches	Y P N		Head Injury	Y P N	
Dizzy spells	Y P N		High fevers	Y P N	

EYES

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

EARS

Earaches	Y P N		Impaired hearing	Y P N	

NOSE AND SINUSES

Frequent colds	Y P N		Nose Bleeds	Y P N	
Stuffiness	Y P N		Hayfever	Y P N	
Sinus problems	Y P N		Loss of smell	Y P N	

MOUTH AND THROAT

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

RESPIRATORY

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

CARDIOVASCULAR

Heart disease	Y P N		Murmurs	Y P N	

URINARY

Frequent urination	Y	P	N	Bed wetting	Y	P	N

GASTROINTESTINAL

Belching/passing gas	Y	P	N	Stomach aches	Y	P	N
Constipation	Y	P	N	Diarrhea	Y	P	N
Bowel Movements	How often _____						

MUSCULOSKELETAL

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

BLOOD/PERIPHERAL VASCULAR

Anemia	Y	P	N	Easy bleeding/bruising	Y	P	N

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

What expectations do you have for your child from working with our clinic?

Welcome! We're honored to be of service for you and your child!