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(Please Print)

PEDIATRIC INTAKE FORM

Patient 's Name _____ Age _____ Today's Date _____/_____/_____
Date of Birth _____/_____/_____ Sex _____ Home Phone _____/_____/_____ SSN_____/_____/_____
Mother's Name _____Cell_____/_____/_____ Father's Name_____Cell_____/_____/_____
Home Address _____ City _____ State _____ Zip _____
Work Phone _____/_____ /_____ Parent's Email _____
Name & Address of Dr's Office/Hospital/Clinic where your child's health records are kept: _____
_____
Reason for referral or presenting problem _____

MEDICATIONS:	NOW	PAST		NOW	PAST		NOW	PAST
Aspirin		_____	_____	Tylenol	_____	_____	Decongestant	_____
Ibuprofen	_____	_____		Antibiotics	_____	_____	Anti-Histamine	_____ _____
Other _____	_____	_____		Allergic to Medicines _____				

MEDICAL HISTORY:
Childhood Illnesses:

_____ Chicken Pox	_____ Scarlet Fever	_____ Tonsillitis - # of Times _____
_____ Measles	_____ Pneumonia	_____ Ear Infections - # of Times _____
_____ Mumps	_____ Frequent Colds	_____ Rubella _____ Rheumatic Fever

_____ Other - Please Specify _____

Has your child had any of the following tests?	WHERE	WHEN	RESULTS
Electroencephalogram			
Psychological Evaluation			
Hearing Test			
Speech/Language Testing			

Injuries/Surgeries/Hospitalizations (please list) _____

IMMUNIZATIONS:

_____ Measles	_____ Polio	_____ MMR	_____ Smallpox	_____ Diphtheria
_____ Mumps	_____ DPT	_____ Tetanus	_____ Influenza	_____ Pneumonia

_____ Other (List) _____

DIET:
Please describe your child's typical daily diet: _____

_____

_____

BIRTH HISTORY:

Term: _____ Full _____ Premature _____ Late Weight at birth _____ lbs _____ oz

Length of Labor _____ Complications ? _____

Has your child has any of the following problems?

_____ Jaundice _____ Diarrhea _____ Birth Defects _____Rashes _____ Colic

_____ Fever _____ Allergies _____ Cerebral Palsy _____Blue Baby _____ Seizures

_____ Birth Injuries _____ Other (Explain) _____

Child's sleep pattern (first year) _____

Food Intolerances (if any) _____

Feeding: Breast fed? _____ How Long? _____ Formula? _____ Milk or Soy _____

Age Began: Solid Foods _____ Sitting _____ Crawling _____ Walking _____ First Words _____

SYMPTOMS: (Mark 1 for Current Symptoms and 2 for Past Symptoms)

_____ Hives _____ Burning of urine _____ Bloody urine _____ Frequent Urination

_____ Eczema _____ Cries Easily _____ Bleeding Gums _____ Heart Murmur

_____ Nervous _____ Nose Bleeds _____ Vomiting Spells _____ Stomach Aches

_____ Acne _____ Anemia _____ Night Sweats _____ High Fever

_____ Jaundice _____ Sensitive to Light _____ Chronic Rash _____ Sleep Problems

_____ Hearing Loss _____ Body/Breath Odor _____ Easy Bruising _____ Motion/Car Sickness

_____ Diarrhea _____ Flat Feet _____ No Appetite _____ Sore Throat

_____ Constipation _____ Nightmares _____ Frequent Headaches _____ Frequent Colds

_____ Gas _____ Canker Sores _____ Bleeding Tendency _____ Unusual Fears

_____ Wheezing _____ Joint Pain _____ Excessive Fatigue _____ Cough

_____ Dizzy Spells _____ Hair Loss _____ Other (Explain) _____

FAMILY HISTORY:

_____ Heart Disease _____ Diabetes _____ Birth Defects _____ Hypertension _____ Arthritis

_____ Tuberculosis _____ Cancer _____ Allergies _____ Mental Illness

Previous pregnancies by natural mother, miscarriages or complications? _____

_____

Mother's age at child's birth _____

Mother's health during pregnancy?

____ Bleeding ____ Nausea ____ Hypertension ____Diabetes ____Illnesses _____ Medications

_____Thyroid Problems _____Physical or emotional trauma _____ Cigarettes, alcohol, drug consumption