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PEDIATRIC INTAKE FORM (BIRTH TO 5 YEARS OLD)

Patient's Name:_____Date:_____
Age: _____ Date of Birth: _____Gender: Female / Male
Parent/Guardian's Name: _____
Address:_____City:_____State:_____Zip:_____
Telephone (home): _____(Parent's work): _____
Parent's email address:_____
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:
_____
Reason for referral or presenting problems:

_____

MEDICATIONS

☐ 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?
Electroencephalogram (EEG):_____Psychological evaluations:_____
Hearing test:_____Speech/language tests:_____
Injuries/surgeries/hospitalizations (please list):_____

IMMUNIZATIONS

Chicken pox	Measles	Diphtheria
Small pox	MMR	DPT
Others:	Mumps	Tetanus
H. influenza	Rubella	Polio
Adverse reactions? If Yes, what?		

FAMILY HISTORY

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

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PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications?

_____

Mother's age at child's birth: _____ Mother's health during pregnancy:_____

☐ Bleeding ☐ Illnesses ☐ Nausea ☐ Physical or emotional trauma
☐ Hypertension ☐ Cigarettes, alcohol, drug consumption
☐ Medications ☐ Diabetes ☐ Thyroid problems

BIRTH HISTORY

☐ ☐ ☐

Term: Full / Premature / Late Length of labor:_____Complications:_____
Birth city & state:_____Birth time:_____ Birth weight: _____

Did you child have any of the following problems shortly after birth?

☐ Rashes ☐ Jaundice ☐ Birth injuries ☐ Blue baby ☐ 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

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

Hives	Burning urine	Bloody urine	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	Dizzy spells	Hair loss
Excessive fatigue	Cough	Allergies	Frequent urination

DIET

Please describe your child's typical daily diet:

_____
_____
_____
_____