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PEDIATRIC INTAKE FORM (6-12 years old)

Name:____Date: ___________

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

Mother's name:______________________Father's name:____________________

Address: ____

City:____________________________ State:__________ Zip Code:_____________

Phone # (home): (_____)_______________ Parent's # (work): (_____)_______________

e-mail address: ____

How did you hear about our clinic?______________________________________

HEALTH HISTORY QUESTIONNAIRE

Birth city & state: ____________________Birth time: ________Birth weight:__________

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

______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 had any of the following tests?

Electroencephalogram (EEG)____

Psychological evaluation____

Hearing tests____

Speech/Language tests____

Hospitalizations/ Surgeries/ Injuries

What hospitalizations, surgeries or injuries has your child had?

____

____

Immunizations

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

Allergies or Hypersensitivies

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, <u>vitamins</u> or other <u>supplements</u> your child is taking:

1)______________________ 5)______________________

2)______________________ 6)______________________

3)______________________ 7)______________________

4)______________________ 8)______________________

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REVIEW OF SYSTEMS

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

MENTAL/ EMOTIONAL			
Mood Swings	Y N P S	Irritability	Y N P S
Anxiety/nervousness	Y N P S	Unusual fears	Y N P S
Hyperactivity	Y N P S	Introvert/extrovert	Y N P S
Cries easily	Y N P S	Motion/car sickness	Y N P S
Nightmares	Y N P S	Sleep problems	Y N P S
NOSE AND SINUSES			
Frequent colds	Y N P S	Nose Bleeds	Y N P S
Stuffines	Y N P S	Hayfever	Y N P S
Sinus problems	Y N P S		
MOUTH AND THROAT			
Breath odor	Y N P S	Frequent sore throat	Y N P S
Canker sores	Y N P S		
ENDOCRINE			
Heat/cold intolerance	Y N P S	Fatigue	Y N P S
Excessive thirst/hunger	Y N P S	High blood sugar	Y N P S
Low blood sugar	Y N P S		
RESPIRATORY			
Cough	Y N P S	Wheezing	Y N P S
Asthma	Y N P S	Bronchitis	Y N P S
CARDIO-VASCULAR			
Heart disease	Y N P S	Murmurs	Y N P S
SKIN			
Hives	Y N P S	Acne	Y N P S
Eczema	Y N P S	Itching	Y N P S
Rashes	Y N P S		
URINARY			
Frequent urination	Y N P S	Bed wetting	Y N P S
HEAD			
Headaches	Y N P S	Head Injury	Y N P S
Dizzy spells	Y N P S	High fevers	Y N P S
GASTRO-INTESTINAL			
Stomach aches	Y N P S	Belching/passing gas	Y N P S
Constipation	Y N P S	Diarrhea	Y N P S
Bowel Movements		How often?	
EYES			
glasses/contacts	Y N P S	tearing or dryness	Y N P S
eye pain/strain	Y N P S		
MUSCULOSKELETAL			
joint pain/ stiffness	Y N P S	muscle spasms	Y N P S
cramps	Y N P S	broken bones	Y N P S
EARS			
earaches	Y N P S	impaired hearing	Y N P S
BLOOD			
Anemia	Y N P S	Easy bleeding	Y N P S
easy bruising	Y N P S		

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?