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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 # (work): (_____)__________________

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

PLEASE COMPLETE BOTH SIDES

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. I look forward to helping your child in any way I can.