PEDIATRIC INTAKE FORM

General Information

Child's name: _____ Date: _____
Name and Relation of person filling out form: _____
Date of birth: _____ Age: ____Wt: ____ Ht: ____ Gender: ____
Address: _____
_____
_____

Contacts

Name and Relation to child: _____
Telephone number: Home: _____ Work: _____
E-mail address: _____ Cell: _____

Present health concerns:
1. _____
2. _____
3. _____
4. _____
5. _____

When did the condition(s) begin? _____
Are there any factors that make the condition(s) worse or better? _____
_____
Current Medicine/Supplements: _____
Any other health concerns? _____
_____

Medical History

How would you describe your general state of health? (Circle)
Excellent Good Fair Poor

Previous Child Illness: ☐ Rubella ☐ Measles ☐ Chicken Pox ☐ Mumps
☐ Pneumonia ☐ Whooping Cough ☐ Strep Throat
☐ Ear Infections ☐ Other: _____

Please indicate all past or current medical conditions, previous illnesses, injuries and or hospitalizations. Include approximate dates.
_____
_____
_____
_____

Allergies (medications, environmental, foods etc.)?
_____
_____
_____
_____

Has your child had these vaccinations: ☐ Chicken Pox ☐ Mumps ☐ Measles ☐ Rubella ☐Meningitis ☐ Tetanus ☐ Diphtheria ☐ Flu ☐ Polio ☐ Pertussis
Was there any reaction to the vaccines? _____

Has your child ever experienced any of the following conditions?
☐ Diaper rash ☐ Cradle cap ☐ Diarrhea ☐ Constipation
☐ High fevers ☐ Heat or cold intolerance ☐ Trouble with bedwetting
☐ Colds ☐ Ear infections, How many and how often? _____
Has the child been hospitalized? For what concern? _____
_____

Pregnancy and Birth

Is the child yours by:
☐ Birth
☐ Adoption
☐ Stepchild
☐ Other: _____

What was the health of the parents at the time of conception (please circle)?
Mother: Poor Good Fair excellent unknown
Father: Poor Good fair excellent unknown

What was the health of the Mother during pregnancy?
Poor fair good excellent unknown

What was the Mother's emotional state during pregnancy?
Poor fair good excellent unknown

What was the Mother's diet during pregnancy?
Poor fair good excellent unknown

What was the Mother's age at the time of birth? _____
How many pregnancies and births did the Mother have? _____

Did the mother experience any of the following during pregnancy?
☐ Bleeding ☐ High blood pressure ☐ Nausea ☐ Vomiting
☐ Diabetes ☐ Thyroid problems ☐Physical or emotional trauma
☐ Other:

Did the mother use any of the following during pregnancy?
☐Tobacco ☐ Alcohol ☐ Recreational drugs:_____
☐Prescription medications:_____
☐Over-the-counter medications:_____
☐Vitamins and/or supplements:_____
☐Other: _____

Were any of the following interventions used during pregnancy?
☐ Ultrasound ☐ Amniocentesis ☐ Chorionic villi sampling ☐ Triple Screen
☐ Maternal serum screening ☐ other: _____
Delivery by: vaginal birth ☐ caesarian ☐ if caesarian, why? _____
Any complications during labour (breech birth): _____

Newborn History

Please indicate any medical problems during the baby's newborn period:_____
Birth weight:_____ Birth length:_____
Term length:_____ Location of birth:_____
Apgar score (0-10): 1 minute_____ 5 minutes_____

Nutrition

Was your child breastfed? No ☐ Yes ☐ if so, how long? _____
Formula? _____
Were there any reactions to formula or breast milk? _____
When did you introduce solid food? _____
What foods were introduced before 6 months? Please list the approximate month that each food was introduced, as well as any reactions that may have occurred?
_____
_____

What foods were introduced at 6-12 months?
_____
_____

Has your child had any unusual feeding/ dietary problems? No ☐ Yes ☐ if so, how long?
_____
Milk intake: Cow milk ☐ (non-fat ☐ 1% ☐ 2% ☐ whole milk ☐) soy ☐ rice ☐
Allergies to food: _____
_____
Did your child experience colic? _____
Does your child have any dietary restrictions? _____

Describe a typical day's diet for your child?
Breakfast_____
Lunch_____
Dinner_____
Snacks_____
Beverages (include total quantity)_____
Appetite:_____

Dental history: First visit: _____ Any problems: _____

Development

How was your child's health in the first year? (Circle)
Excellent Good Fair Poor

At what age did your child: Roll over_____ Sit alone_____ Crawl_____
Walk_____ Say words_____ Toilet train_____ Teething_____ Any difficulties with teething?_____

Sleep

Hours per night: _____ Naps (number and length): _____
Any sleep problems:_____
Does your child have nightmares? Yes or No, and how often? _____
Does your child sleep alone? Yes or No

Social History and Environment

Are the child's parents ☐ married ☐ unmarried ☐ separated ☐ divorced, when? _____

Parents occupation: Mother_____ Father_____

Is violence at home a concern? ☐ No ☐ Yes
Household pets:_____ Allergens:_____
Do any family members smoke in the house? ☐ No ☐ Yes
Does your child have any environmental or chemical sensitivities (ie. perfumes, odors, soaps): _____

School history: ☐ home-care ☐ preschool ☐ grade school _____
Any school performance concerns:_____
What are your child's interests and favorite activities? _____
_____

Sports/ exercise: type_____ how often? _____
How would you describe your child's temperament/personality? _____
Is there anything you would want to change? _____
How much television does your child watch? _____

Family History

(Please check any of the following and indicate the family member)

☐ Alcoholism/ dug abuse	☐ Heart disease or stroke	☐ Seizures
☐ Psychiatric disorders	☐ Thyroid disease	☐ Kidney disease
☐ High blood pressure	☐ Clotting disorders	☐ Birth defects
☐ Asthma/ hay fever	☐ Inherited disease	

Do either of the parents have any chronic illnesses? _____
_____

Relation to child	Age	Health Concerns?
Mother		
Father		
Brother		
Sister		
Maternal grandmother		
Maternal grandfather		
Paternal grandmother		
Paternal grandfather		

Are there any other important factors or concerns to be noted? _____
_____
_____
_____