PEDIATRIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name ______________________

Address ______________________

City ______________________ State __________

Home Phone ______________________

Cell Phone ______________________

Email ______________________

Sex ❑ M ❑ F Age ______ Birthday __________

IN CASE OF EMERGENCY, CONTACT

Name ______________________

Relationship ______________________

Contact Number ______________________

Mother's Name ______________________

Mother's Occupation ______________________

Mother's Phone ______________________

Mother's Email ______________________

Father's Name ______________________

Father's Occupation ______________________

Father's Phone ______________________

Father's Email ______________________

Who may we thank for referring you?

____

HOW CAN WE HELP YOUR CHILD?

❑ Wellness Checkup ❑ Other: ______________________

If your child is already experiencing a symptom, please describe it:

Has your child been treated on an emergency basis? ❑ Yes ❑ No

Please describe: ______________________

PREGNANCY HISTORY

Did you experience any complications during your pregnancy? (check all that apply)

❑ Back/Other Pain ❑ Gestational Diabetes ❑ Pre/Eclampsia ❑ Strep B ❑ Nauseau/Vomitting

❑ Pre-Term ❑ Fatigue ❑ Swelling ❑ Other (please describe) __________

BIRTH HISTORY

Type of birth (check all that apply):

❑ Hospital ❑ Birth Center ❑ Home ❑ Normal / Vaginal ❑ Breech

❑ Cesarean ❑ Scheduled/Induced ❑ Epidural

Problems during labor / delivery? ______________________

❑ Antibiotics ❑ Congenital Anomalies ❑ Failure to Thrive ❑ Jaundice ❑ Meconium

❑ Respiratory Distress ❑ Extended Hospitalization ❑ Other __________

GROWTH & DEVELOPMENT

Infant feeding: ❑ Breast ❑ Bottle ❑ Formula

Number of hours of sleep each night: ______________ Quality of sleep: ______________

At what age did the child:

Respond to sound: ______________ Crawl: ______________ Hold head up: ______________

Stand: ______________ Sit unsupported: ______________ Walk unsupported: ______________

CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Has your child had (check all that apply)?:

❑ Chicken Pox ❑ Measles ❑ Rubeola

❑ Mumps ❑ Rubella ❑ Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?:

❑ Allergies
❑ Anemia
❑ Arm Problems
❑ Asthma
❑ Back Aches
❑ Bed Wetting
❑ Behavioral Problems
❑ Broken Bones
❑ Chronic Ear Aches
❑ Colds/Flu
❑ Colic
❑ Convulsions/Seizures
❑ Delayed Speech
❑ Diabetes
❑ Digestive Issues (constipation/diarrhea)
❑ Dizziness
❑ Fainting
❑ Headaches
❑ Heart Trouble
❑ Hyperactivity
❑ Hypertension
❑ Jeuvenile Rheumatroid Arthritis
❑ Joint Problems
❑ Leg Problems
❑ Neck Problems
❑ Neuritis
❑ Orthopedic Problems
❑ Paralysis
❑ Poor Appetite
❑ Ruptures/Hernias
❑ Sinus Trouble
❑ Tuberculosis
❑ Walking Problems

Have you vaccinated your child?

❑ No ❑ Yes ❑ As scheduled ❑ Delayed Schedule

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list)

____

____

MEDICATIONS (list)

____

____

SURGERIES (list)

____

____

FAMILY HISTORY (list)

____

____

SIBLINGS

How many children do you have? ______________

Children's' Ages: ______________

Childrens' health concerns: ______________

____

Number of pregnancies: ______________

Are you currently pregnant? ❑ No ❑ Yes, I'm due: ______________

Health concerns regarding this pregnancy? ______________

____

Authorization for Care of Minor

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Signed: ______________ Witnessed: ______________ Date: ______________