

PEDIATRIC INTAKE & HISTORY



PATIENT INFORMATION

Patient Name _____
Address _____
City _____ State _____
Home Phone _____
Cell Phone _____
Email _____
Sex M F Age _____ Birthday _____

Mother's Name _____
Mother's Occupation _____
Mother's Phone _____
Mother's Email _____

Father's Name _____
Father's Occupation _____
Father's Phone _____
Father's Email _____

IN CASE OF EMERGENCY, CONTACT

Name _____
Relationship _____
Contact Number _____

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

Number of pregnancies: _____

Children's' Ages: _____

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

Childrens' health concerns: _____

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: _____