

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_



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### Pediatric Intake Form

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex M or F

Grade of School: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Mother's Name and occupation: \_\_\_\_\_

Father's Name and occupation: \_\_\_\_\_

Parents are (circle): Married Separated Divorced Living Together Other

Regular Pediatrician name and city located in: \_\_\_\_\_

Reason for Office Visit: \_\_\_\_\_

Has child been seen by any other doctor(s) for this complaint? Yes No Past

Has child had any blood work done? If yes, please list what:  
 \_\_\_\_\_

Please list any operations or hospitalizations and year occurred:

- 1.
- 2.
- 3.

Please list all medicines (from drugstore or prescription) child is on now:

- 1.
- 2.
- 3.
- 4.

Please list all supplements child is taking:

- 1.
- 2.
- 3.
- 4.

Any known Allergies to food, drugs, environment, animals: \_\_\_\_\_  
 \_\_\_\_\_

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**Previous medical history**

**Yes** indicates the child gets the problem regularly; **No** indicates the child never had the problem; **Past** indicates the child had the problem in the past but not recently. Please circle the correct one for your child.

Ear Infections?      Yes    No    Past      If has had, how many total? \_\_\_\_\_

Colds?              Yes    No    Past      If has had, how many total? \_\_\_\_\_

Strep throat?      Yes    No    Past      If has had, how many total? \_\_\_\_\_

How many times has the child taken antibiotics: \_\_\_\_\_

What other medicines has the child taken? And how often?

1.

2.

3.

4.

Hearing tests Normal:      Yes    No    Not Tested

Vision Tests Normal:      Yes    No    Not Tested

Any speech impediments:    Yes    No    Past

Learning impediments:      Yes    No    Don't know

**Vaccination History:** **Yes**, has had; **No**, has not; **Some**, did not finish all shots

MMR:              Yes    No    Some              DPT:              Yes    No    Some

Hep B:             Yes    No    Some              Hib:              Yes    No    Some

Chickenpox:      Yes    No    Some              Polio:             Yes    No    Some

Other: \_\_\_\_\_

Any reactions to vaccinations? If so, please explain: \_\_\_\_\_

**Family history**

Allergies:                      Yes    No                      Obesity:              Yes    No

Cancer:                        Yes    No                      Tuberculosis:      Yes    No

Cardiovascular disease:    Yes    No                      Mental Illness:    Yes    No

Diabetes mellitus:            Yes    No

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**Mother's Pregnancy history**

Age at conception: \_\_\_\_\_

Did she have other children already? Yes No

**Health During Pregnancy**

Smoking: Yes No

Diabetes: Yes No

Coffee: Yes No

Nausea/Vomiting: Yes No

Recreational drugs: Yes No

Emotional Stress: Yes No

Preeclampsia: Yes No

Length of Labor: \_\_\_\_\_

Vaginal birth: Yes No

Traumatic birth: Yes No

If the birth was difficult, please explain:

\_\_\_\_\_

Health of baby at birth: \_\_\_\_\_

Child breastfed: Yes No

For how long: \_\_\_\_\_

When put on formula: \_\_\_\_\_

What formula was used: \_\_\_\_\_

When was child put on solid food: \_\_\_\_\_

When did child walk: \_\_\_\_\_

Talk: \_\_\_\_\_

When did child develop teeth: \_\_\_\_\_

**Health History of child**

Jaundice as baby: Yes No

Colic: Yes No

Cradle cap: Yes No

Anemia: Yes No

Eczema or psoriasis: Yes No

Asthma: Yes No

Diarrhea: Yes No

Warts: Yes No

Constipation: Yes No

Nightmares: Yes No

Finicky eating: Yes No

Bed-wetting: Yes No

Poor teeth: Yes No

Tantrums: Yes No

Chronic sniffles: Yes No

Disobedient: Yes No

Bad foot odor: Yes No

Fears/Phobia: Yes No

Very sweaty baby/child: Yes No

Diaper Rash: Yes No

Hyperactivity: Yes No

Early Puberty: Yes No

Growing pains: Yes No

Stomach aches: Yes No

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**Any particular household stressors child has witnessed or gone through:**

1. \_\_\_\_\_

2. \_\_\_\_\_

**Diet**

Foods: Please list in each food group, the foods that your child currently eats. Grain would include all breads, pasta and other related foods.

Meat: \_\_\_\_\_ Fruit: \_\_\_\_\_ Veg: \_\_\_\_\_ Grain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other: \_\_\_\_\_

**Typical Day's Diet:**

Breakfast: \_\_\_\_\_

Snack: \_\_\_\_\_

Lunch: \_\_\_\_\_

Snack: \_\_\_\_\_

Supper: \_\_\_\_\_

Snack: \_\_\_\_\_

**Toxin Exposure:**

Has the child ever lived near a refinery or other highly polluted area? \_\_\_\_\_

Has the child ever lived in a house with lead paint? \_\_\_\_\_

Has the child ever lived in a house that had new paint, cabinets, carpeting installed and did that seem to affect their health at all? \_\_\_\_\_

Do you spray pesticides or herbicides around the house or use other toxic chemicals?  
\_\_\_\_\_

Does the child seem particularly sensitive to perfumes or other vapors? \_\_\_\_\_

**Additional Comments can be noted on back of last page.**