

PEDIATRIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____ Mother's Name _____
Address _____ Mother's Occupation _____
City _____ State/Zip _____ Mother's Phone _____
Home Phone _____ Mother's Email _____
Cell Phone _____
Email _____ Father's Name _____
Sex ☐ M ☐ F Age _____ Birthday _____ Father's Occupation _____
IN CASE OF EMERGENCY, CONTACT Father's Phone _____
Name _____ Father's Email _____
Relationship _____ **Who may we thank for referring you?**
Contact Number _____

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)

<input type="checkbox"/> Back/Other Pain	<input type="checkbox"/> Gestational Diabetes	<input type="checkbox"/> Pre/Eclampsia	<input type="checkbox"/> Strep B	<input type="checkbox"/> Nausea/Vomiting
<input type="checkbox"/> Pre-Term	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Swelling	<input type="checkbox"/> Other (please describe) _____	

BIRTH HISTORY

Type of birth (check all that apply):

<input type="checkbox"/> Hospital	<input type="checkbox"/> Birth Center	<input type="checkbox"/> Home	<input type="checkbox"/> Normal / Vaginal	<input type="checkbox"/> Breech
<input type="checkbox"/> Cesarean	<input type="checkbox"/> Scheduled/Induced	<input type="checkbox"/> Epidural		

Problems during labor / delivery? _____

<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Congenital Anomalies	<input type="checkbox"/> Failure to Thrive	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Meconium
<input type="checkbox"/> Respiratory Distress	<input type="checkbox"/> Extended Hospitalization	<input type="checkbox"/> 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):

- | | | |
|--------------------------------------|----------------------------------|---|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles | <input type="checkbox"/> Rubiola |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Rubella | <input type="checkbox"/> Pertussis/Whooping Cough |

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

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

Children's 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: _____