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# Pediatric Intake Form

Name: _____Date: _____
(First) (Middle) (Last)
Address: _____ City:_____ State: _____ Zip: _____
Date of Birth:_____ Current Age:_____ Gender:_____
Mother's Name:_____ Father's Name:_____
Home Phone:_____ Parent's Cell Phone:_____
Parent's Email:_____

Emergency Contact:_____ Telephone:_____ Relationship:_____

Whom may we thank for referring you to us? _____

*Successful health care is only possible when the practitioner has a thorough understanding of the patient physically, mentally, and emotionally. Please complete the following questionnaire as thoroughly as possible.*

Is your child currently receiving health care: [Yes] [No]
If yes, where and from whom? _____
If no, When and where did you last receive health care?_____
For what reason?_____

Please identify below the health concerns that have brought you to the clinic:
Condition Past Treatment
1_____
2_____

**Primary Health Concern:**
When condition began: _____ Have you had this in the past? [Yes] [No]
Is your condition: [ ] Getting worse [ ] Staying constant [ ] Coming & going
What makes it better? _____
What makes it worse? _____
What diagnosis have you been given? _____
What kinds of treatment have you tried? _____

**Secondary Health Concern:**
When condition began: _____ Have you had this in the past? [Yes] [No]
Is your condition: [ ] Getting worse [ ] Staying constant [ ] Coming & going
What makes it better? _____
What makes it worse? _____
What diagnosis have you been given? _____
What kinds of treatment have you tried? _____

Height: _____ Weight: _____ Blood Pressure _____/_____

Does your child have any chronic infectious disease? [Yes] [No]

If yes, please explain: _____

Is your child suffering from any chronic illnesses? [Yes] [No]

If yes, please explain: _____

Significant diseases, injuries, hospitalizations, surgeries, X-rays/CAT scans/MRI's/NMR's/etc

Reason When Results (if applicable)

_____

_____

_____

Please list any prescription medications, over-the-counter medications, vitamins or supplements that your child is currently taking:

Medication/Vitamin/Supplement Dosage Frequency Reason

_____

_____

_____

Please list any past prescription medications: _____

_____

Please list any foods, drugs, substances, or medications your child is hypersensitive or allergic to:

_____

**Immunizations** (please circle any that your child has had):

Polio Tetanus Measles/Mumps/Rubella Pertussis Diphtheria Hepatitis B Influenza

Prevnar Chicken Pox Others: _____

Any adverse reactions to vaccines? [Yes] [No] If yes, please describe: _____

| **Family History** | Mother | Father | Brother(s) | Sister(s) |
|---|---|---|---|---|
| Age [if living] | | | | |
| Health [G=good, P=poor] | | | | |
| Age at death [if deceased] | | | | |
| Cause of death | | | | |
| **Family Illnesses** | Mother | Father | Brother(s) | Sister(s) |
| Allergies | | | | |
| Asthma | | | | |
| Birth Abnormality | | | | |
| Cancer | | | | |
| Celiac Disease | | | | |
| Diabetes | | | | |
| Eczema | | | | |
| Heart Disease | | | | |
| High Blood Pressure | | | | |
| Kidney Disease | | | | |
| Mental Illness | | | | |

**Birth Mother's Prenatal History-**

Mother's age at child's birth? _____ Mother's health during pregnancy? _____

Were any of the following experienced during pregnancy?

[Bleeding] [Physical or emotional trauma] [High blood pressure] [Nausea/Vomiting]

[Depression/Anxiety] [Thyroid problems] [Illnesses] [Gestational diabetes]

Consumption of: [Cigarettes] [Alcohol] [Drugs]

Surgery: _____

Other: _____

**Child's Birth History-**

Term: [Premature] _____ weeks [Full] [Late] _____ weeks

Length of labor: _____ Any complications? _____

_____

Delivery: [Vaginal] [C-section] [Induced] [Forceps] [Suction] [Anesthesia used]

At birth: Weight _____lbs. _____oz. Height _____inches

Did your child have any of the following problems shortly after birth?

Birth abnormality _____ Birth injuries _____

[Blue baby] [Cerebral palsy] [Seizures] [Jaundice] [Colic] [Fever] [Rashes]

Other: _____

**Feeding & Development-**

Breastfed? [Yes] [No] If yes, how long? _____ Reason discontinued_____

Formula? [Yes] [No] If yes: [cow's milk] [soy] [other]_____

Age began solids _____ which food? _____

Age began: Sitting_____ Crawling_____ Walking_____ Talking_____

Age your child: Cut their first tooth_____ Lost their first tooth_____

Any deviations off of the standard expected growth chart for height/weight? [Yes] [No]

If yes, please describe: _____

How would you describe your child's temperament? _____

**Energy and Immunity-** please circle any that apply

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue

Catch Colds Easily Suppressed Immune System History of Antibiotic Usage

**Head, Eye, Ear, Nose & Throat-** please circle any that apply

Glasses Eye Strain Eye Pain Red/Itchy Eyes See Floating Black Spots Night Blindness

Ear Ringing Poor Hearing Ear Aches Headaches/Migraines Concussions Mouth Sores

Swollen Glands Sinus Problems Frequent Sore Throat TMJ/Jaw Problems Dry Mouth

Teeth Problems Gum Problems Hay Fever/Allergies Other_____

**Respiratory-** please circle any that apply

Pneumonia Frequent Common Colds Difficulty Breathing Persistent Cough Asthma

Bronchitis Difficulty Breathing When Lying Down Other_____

**Genito-Urinary Tract-** please circle any that apply

Nighttime Urination History of Kidney Stone Other_____

Urine Color: Normal / Clear / Dark Yellow / Reddish / Cloudy

Urine Flow: Scanty / Has Odor / Burning / Painful / Difficult / Urgent

**Gastrointestinal-** please circle any that apply

Nausea/Vomiting Epigastric Pain Abdominal Pain Heartburn Gas/Bloating Low Appetite
Large Appetite Bad Breath Fatigue After Eating

Stools: Hard Soft Formed Loose Sticky Black Blood Mucus Undigested Food
Floats Sinks Frequency of Bowel Movements _____ X [Day] [Week]

**Sleep-**

# of Hours of nighttime sleep: _____ Fall asleep _____AM/PM Wake up _____ AM/PM
Naps: [Yes] [No] If yes, what time and for how long? _____
Difficulty Falling Asleep Why? _____
Difficulty Staying Asleep Waking When? _____
Dreams [Yes] [No] Sleep Quality [Good] [Poor] Wake Feeling Rested [Yes] [No]

**Lifestyle-**

a. Please indicate typical food and beverage intake:

| Breakfast | Lunch | Dinner | Snacks |
|---|---|---|---|
| | | | |

b. Any dietary restrictions (religious, vegetarian, vegan, etc.)? _____
c. Quantity of Fluids Consumed Daily: Water _____ Other _____
d. Exercise – Type: _____ How often: _____
e. Approximate TV/Computer/Electronics hours per day: Homework _____ Play _____
f. Other _____

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**If your child has begun or gone through puberty, please continue. If not, then you are done.**

**Female Reproductive-** please circle any that apply

Age of first period _____ Date last period began _____ Date of last PAP _____
Average number of days of flow _____ Average number of days in cycle _____
Is menses regular? [Yes] [No] The flow is: [ ] Heavy [ ] Normal [ ] Light
Average # of tampons/pads used per day: 1st____ 2nd ____3rd _____ 4th _____ 5th _____ 6th _____ 7th _____
The color is: [ ] Fresh Red [ ] Dark Red [ ] Pale Red [ ] Purple [ ] Brown [ ] Other
Do you have the following menstruation related signs/symptoms?

[ ] Bleeding between cycles [ ] Nausea
[ ] Breast distention/tenderness [ ] PMS
[ ] Heavy vaginal discharge between periods [ ] Cramps
[ ] Pelvic pain [ ] Blood clots

Sexually active [Yes] [No] Pregnant/possibility of pregnancy? [Yes] [No] # of weeks _____

**Male Reproductive-** please circle any that apply

Premature Ejaculation External Genitalia have sensations of : Cold / Numbness / Pain / Swelling
Erectile Dysfunction Prostate Problems Sexually active [Yes] [No] Other_____