PEDIATRIC INTAKE FORM (BIRTH TO 5 YEARS)

Patient's Name: ____ Date: _______________

Age: ________ Date of Birth: __________________________ Gender: Female / Male

Parent/Guardian's Name: ____

Address: ____

City: _______________________________ State: ______________ Zip: ____________________

Telephone (home): __________________________ (Parent's work):__________________________

Parent's email address: ____

How did you hear about this clinic? Another practitioner ______________ ND directory __________

Friend/family member ________________ Google search Brochure/Business Card Public Presentation

Professional Seminar Other________________________

Has any other family member already been a patient at this clinic?_________________________

Name of doctor's office/hospital/clinic where your child's health records are kept:_______________

____

Reason for referral or presenting problems: ____

____

____

MEDICATIONS

NOW	PAST		NOW	PAST	
____	____	Aspirin	____	____	Decongestants
____	____	Tylenol	____	____	Anti-histamine
____	____	Antibiotics	____	____	Other ______________________________

MEDICAL HISTORY

____ Chicken pox	____ Scarlet fever	____ Tonsillitis, approx no. of times: __________
____ Measles	____ Pneumonia	____ Ear infections, approx no. of times: ________
____ Mumps	____ Frequent colds	____ Strep throat, approx no. of times: __________
____ Rubella	____ Rheumatic fever	____ Other: ______________________

Has your child ever had any of the following? When Where Results

Electroencephalogram (EEG): ____

Psychological evaluations:____

Hearing test: ____

Speech/language tests: ____

Injuries/surgeries/hospitalizations (please list): ______________________________________

____

IMMUNIZATIONS

____ MMR	____ DPT	____ Chicken pox	Others:________________________
____ Measles	____ Diphtheria	____ Small pox	Adverse reactions: Y / N
____ Mumps	____ Tetanus	____ H. influenza	If so, what? ___________________
____ Rubella	____ Polio	____ The flu	______________________________

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FAMILY HISTORY

____ Heart disease	____ Diabetes	____ Birth defects
____ Hypertension	____ Arthritis	____ Tuberculosis
____ Cancer	____ Allergies	____ Asthma
____ Mental illness	____ Osteoporosis	____ Other significant: ______________________

____
____

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications? ______________________
____

Mother's age at child's birth: ______

Mother's health during pregnancy:

____ Bleeding	____ Nausea	____ Physical or emotional trauma
____ Illnesses	____ Hypertension	____ Cigarettes, alcohol, drug consumption
____ Medications	____ Diabetes	____ Thyroid problems

BIRTH HISTORY

Term: ____Full____ Premature____ Late Length of labor: _______ Complications:____________________

Birth city & state: ______________________________ Birth time: _________ Birth weight:_________

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

____ Rashes	____ Birth injuries	____ Blue baby
____ Jaundice	____ Seizures	____ Cerebral palsy
____ Colic	____ Fever	____ Birth defects

____ Other: ____

Child's sleep patterns (1st year): ____

Food intolerances: ____

Breast fed: Y / N How long: __________ Formula: Y / N Type (milk, soy):__________________

Age began solids: _________ Which foods:____

Age began: Sitting _______ Crawling _______ Walking _______ Talking ________

SYMPTOMS

____ Hives	____ Burning urine	____ Bloody uring	____ Eczema
____ Cries easily	____ Bleeding gums	____ Heart murmur	____ Nervous
____ Nose bleeds	____ Vomiting spells	____ Sleep problems	____ Asthma
____ Acne	____ Anemia	____ Night sweats	____ High fevers
____ Jaundice	____ Sensitive to light	____ Chronic rash	____ Stomach aches
____ Diarrhea	____ Hearing loss	____ Easy bruising	____ Sore throats
____ Flat feet	____ No appetite	____ Body/breath odor	____ Constipation
____ Nightmares	____ Frequent colds	____ Bleeding tendency	____ Unusual fears
____ Wheezing	____ Joint pains	____ Excessive fatigue	____ Cough
____ Dizzy spells	____ Hair loss	____ Frequent urination	____ Allergies

DIET

Please describe your child's typical daily diet:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

To drink: ____

Thank You. We look forward to helping your child in any way we can.