PEDIATRIC INTAKE & HISTORY

PATIENT INFORMATION

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

IN CASE OF EMERGENCY, CONTACT

Name _____
Relationship _____
Contact Number _____

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

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

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 ☐ Nausea/Vomiting
☐ 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 ❑ Robiola

❑ 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: _____

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: _____