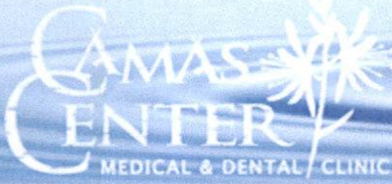


Pediatric Intake Form

Patient & Parent or Guardian Information:

PATIENT Name: ____ Date: ____________________
Age: ___________________ DOB: ___________________ Gender: Female / Male
Telephone (Home): ______________________________ Work: ______________________________
Parents Email Address: ____
Mothers Name & Occupation: ____
Fathers Name & Occupation: ____
Parents are: _____Married _____ Separated _____Divorced _____Living together ____Other
Name of child's Provider: ______________________________ **Phone:** ____________________

Most Important CURRENT Health Concerns:

1. ____
2. ____
3. ____

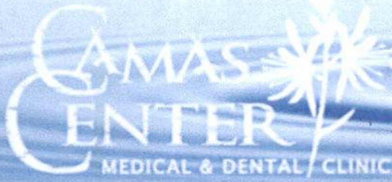
Allergies: ____

Medications & Supplements:

1. Medication: ______________________________ Dose: ______________________________
2. Medication: ______________________________ Dose: ______________________________
3. Medication: ______________________________ Dose: ______________________________

Medical HISTORY (Please Circle):

1. ADD/HD
2. Allergies
3. Anemia
4. Asthma
5. Bleeding gums
6. Bloody urine
7. Burning urin
8. Chicken pox
9. Chronic rashes
10. Colic
11. Constipation
12. Cough
13. Cradle cap
14. Diaper rash
15. Diarrhea
16. Dizzy spells
17. Ear infections
18. Early puberty
19. Easy bruising
20. Easy bleeding
21. Eczema
22. Excessive fatigue
23. Flat feet
24. Frequent colds
25. Frequent urination
26. Growing pains
27. Hair loss
28. Hearing loss
29. Heart murmur
30. High fevers
31. Hives
32. Jaundice
33. Joint pains
34. Loss of appetite
35. Measles
36. Mumps
37. Nervousness
38. Nightmares
39. Night sweats
40. Nose bleeds
41. Pneumonia
42. Poor teeth
43. Rheumatic fever
44. Rubella
45. Scarlet fever
46. Sensitive to light
47. Sleep problems
48. Sore throat
49. Stomach aches
50. Strep throat
51. Tantrums
52. Tonsillitis
53. Vomiting spells
54. Wheezing
55. Unusual fears



Pediatric Intake Form

Is there a family history of the following? (Please Circle)

Heart Disease__________ Diabetes (I or II ?) Birth Defects Allergies Hypertension
Arthritis Tuberculosis Asthma Mental Illness____________ Osteoporosis
Cancer _____________ Autoimmune________________ Gastrointestinal disorder _______________
Other: ____

Immunizations:

___MMR ___TDaP/DTaP ___Chicken Pox ___Small Pox __HPV
___Measles ___Diphtheria ___H. Influenza (Hib) ___Hepatitis B __Pneumonia
___Mumps ___Tetanus ___Rubella ___Polio __Hep A
___Rotavirus ___Influenza ___Covid
Others: ____ Adverse Reaction: Yes / No

Has Your Child Ever Had Any of the Following? When? Results?

Electroencephalogram (EEG): ____
Psychological Evaluations: ____
Hearing Test: ____
Speech/ Language Tests: ____
Injuries/Surgeries/Hospitalizations: ____
____
____

Prenatal History:

Mothers Age at Birth: ___________
Mothers Health during Pregnancy:
___Bleeding ___Physical or Emotional Trauma ___Illnesses ___Nausea
___Hypertension ___Cigarettes/Alcohol/Drug Consumption ___Medications ___Diabetes
___Thyroid Problems

Birth History:

Term: Full / Premature / Late Length of Labor: ___________________________________
Any Complications? ____

Did your Child have any of the Following Problems Shortly After Birth?

Rashes Birth Injuries Blue Baby Colic Birth Defects
Jaundice Seizures Cerebral Palsy Fever
Other: ____

Family Health Habits:

How often does your child use a seatbelt/car seat?
A. Never B. Rarely C. Sometimes D. Often E. Always
Does your child ride a bicycle or a horse? If yes, how often does he/she use a helmet?
A. Never B. Rarely C. Sometimes D. Often E. Always
Do you feel that you live in a safe place? Yes / No
In the past year, have you ever felt threatened in your home? Yes / No

Pediatric Intake Form

Do you have a fire escape plan for your home? A fire extinguisher? A smoke alarm? A CO alarm?
Yes / No Yes / No Yes / No Yes/ No

In the past year, has your partner or other family member pushed you, punched you, kicked you, hit you, or threatened to hurt you? Yes / No

If you have a gun at home, is it locked up somewhere safe? Yes / No

Does anyone in the household smoke? Yes / No

Besides you, does anyone else take care of the child? Yes / No If Yes, Who? ______________________

Do you have any Concerns about Your Childs Behavior or Development?

____

Additional Comments:

____

____

____

Parent or Guardian's Name: ____

Signature of Parent or Guardian: ____________________________________ **Date:** ______________

How did you hear or learn about us?

Referred by (circle one): Friend Family Member Workmate Other (Name):

____

Internet search: Please circle one: Google Yahoo Instagram Facebook Twitter Other
Insurance website Magazine article