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PEDIATRIC INTAKE

Patient's Name_____ Date_____

Street Address_____ Apt._____

City_____ State _____Zip_____

Home Phone_____ Work Phone _____

Cell Phone _____ Email _____

Birth Date (include year) _____ Age _____ Gender _____

Mother's name _____ Occupation _____

Father's name _____ Occupation _____

Parents are: _____Married _____Separated _____Divorced _____Other: _____

Siblings of the patient and their ages:_____

Whom may we thank for referring you?_____

Emergency Contact: Name _____ Phone _____

Patient Condition

Reason for Office Visit: _____

Has your child been seen by any other doctor(s) for this complaint?
_____

Is this condition the result of an accident? _____

Other Doctor's Name and Phone:
_____

Date of last physical exam: _____

MOTHER'S PREGNANCY HISTORY

Any fertility treatments: _____

Mom's Age at Birth: _____

During pregnancy did any of the following occur?

Preeclampsia: **Y N** Diabetes: **Y N** Nausea/Vomiting: **Y N**

Recreational Drugs: **Y N** Alcohol: **Y N** Smoking: **Y N**

Dietary Restrictions during pregnancy:

_____

Any genetic testing, amniocentesis: If so, what were the results:

_____

_____

Medications during pregnancy:

_____

Any complications during pregnancy?:

_____

Length of Labor: _____ Delivery method:_____

Birth interventions: _____Vacuum _____Induction _____Forceps _____C Section _____none

Any postpartum complications?: _____

CHILD'S MEDICAL HISTORY

Gestational age at birth (weeks at birth): _____

Apgar scores: _____

Birth Weight: _____ Birth Length: _____

Complications during the birth or after delivery:

_____

Child breastfed? _____ How long?_____
Formula begun? _____ What age? _____ What kind? _____
Age solid food begun? _____ First foods? _____
When did child sit up: _____ Crawl: _____ Walk: _____
Talk: _____ Develop teeth: _____

Were developmental milestones reached? _____

Child evaluated for developmental delay? _____

Any diagnosis received, and by whom? _____

Has your child had any serious illnesses or health challenges? Please list here:

_____
_____
_____
_____

Hearing test abnormalities:	Yes	No	Not Tested
Vision test abnormalities:	Yes	No	Not Tested
Learning Impediments:	Yes	No	Not Tested
Has your child received vaccinations? Which ones?	Yes	No	Not Tested

_____
_____

Any reactions to vaccinations? If so, please explain:

_____

_____

Any traumas, falls, injuries? If so, please explain:

_____

_____

Allergies to food, drugs, environment, animals, etc:

_____

_____

List all surgeries and hospitalizations, including date occurred:

_____

_____

Other symptoms:

_____

_____

List all medications (from drugstore or prescription) child is taking now and dosages if known:

_____
_____
_____

List all supplements child is now taking, and dosages if known:

_____
_____
_____

Medications the child has taken in the PAST:

_____
_____

Current and Past Issues:
Y = Yes N = No P = Past

Jaundice as a baby	Y	N	P	Finicky Eating	Y	N	P
Cradle Cap	Y	N	P	Anemia	Y	N	P
Eczema or Psoriasis	Y	N	P	Stomach Aches	Y	N	P
Diarrhea	Y	N	P	Asthma	Y	N	P
Constipation	Y	N	P	Growing Pains	Y	N	P
Diaper Rash	Y	N	P	Nightmares	Y	N	P
Reflux	Y	N	P	Bed-Wetting	Y	N	P
Ear infection	Y	N	P	Excessive Tantrums	Y	N	P
Colic	Y	N	P	Defiant	Y	N	P
Very Sweaty	Y	N	P	Fears/Phobias	Y	N	P
Nasal Congestion	Y	N	P	Hyperactivity	Y	N	P
Growing pains	Y	N	P	Early Puberty	Y	N	P

Other symptoms or concerns:

TYPICAL DAY'S DIET

Breakfast:

Lunch:

Dinner:

Snacks:

_____

_____

Family History

Allergies: Y N P Obesity: Y N P Cancer: Y N P

Diabetes: Y N P Mental Illness: Y N P Heart Disease: Y N P

Other diseases in your family:_____

If answers yes to any of the above, please write relationship of family member to child and severity of the disease:

_____

_____

_____

_____

OTHER QUESTIONS:

Please list any questions you would like to address during this appointment:

_____

_____

_____

Specialists

(OB, Gastroenterologist, Psychiatrist, Counselor, etc.)

Specialty/Seen for:_____

Name/Office: _____

Phone Number: _____

Specialty/Seen for: _____

Name/Office: _____

Phone Number: _____