P E D I A T R I C I N T A K E F O R M

Parent/Guardian, please take the time to accurately complete this form. The information you contribute is valuable in providing effective health care for your child.

Name: _____ Date: _____

Parent/Guardian: _____

Phone: _____ Cell: _____

Address: _____

Age: _____ Date of Birth: _____

Weight: _____ Height: _____

What are your chief concerns regarding your child's health?

_____

_____

_____

If there is a specific condition, when did it start?

_____

_____

List practitioners seen for this condition:

_____

_____

Is there a family history of this condition?

_____

_____

List any supplements, medications, homeopathic/botanical preparations your child is currently taking, including dosage and duration:

_____

_____

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List any major illnesses, surgeries, hospitalizations, x-rays your child has received. Please include dates:

_____

_____

_____

_____

When was your child last well? _____

Has your child ever had any of the following conditions?

- ☐ Rubella (German Measles)
- ☐ Whooping Cough
- ☐ Chicken Pox
- ☐ Strep Throat
- ☐ Measles
- ☐ Scarlet Fever
- ☐ Mumps
- ☐ Impetigo
- ☐ Roseola
- ☐ Mononucleosis
- ☐ Ear Infections

FAMILY HISTORY

Please check appropriate box and indicate which family member:

Disease	Family Member
☐ Alcoholism	
☐ Allergies	
☐ Arteriosclerosis	
☐ Arthritis	
☐ Asthma	
☐ Bed Wetting	
☐ Birth Defects	
☐ Cancer	
☐ Cataracts	
☐ Celiac Disease	
☐ Colitis	
☐ Depression	
☐ Diabetes	
☐ Epilepsy	
☐ Heart Disease	
☐ Hyperactivity	
☐ Kidney Disease	
☐ Learning Disability	
☐ Mental Disease	
☐ Muscular Dystrophy	
☐ Multiple Sclerosis	

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FAMILY HISTORY CONTINUED

Please check appropriate box and indicate which family member:

Disease	Family Member
☐ Schizophrenia	
☐ Stomach Ulcers	
☐ Stroke	
☐ Tuberculosis	
☐ Yeast Infections	
☐ Venereal Disease	
☐ Other*	
*	

PRENATAL HISTORY

Mother's age at child's birth: _____

Please check appropriate boxes regarding mother's pregnancy:

- ☐ Alcohol Use
- ☐ Bleeding
- ☐ Cigarette Use
- ☐ Diabetes
- ☐ Drug Use
- ☐ Hypertension
- ☐ Illnesses
- ☐ Nausea
- ☐ Medications
- ☐ Physical or Emotional Trauma
- ☐ Thyroid Problems

List any supplements/vitamins taken during pregnancy:

_____

_____

_____

Did the mother smoke before pregnancy? If so, How much?

_____

Does anyone in the household currently smoke?

_____

Mother's diet during pregnancy was: poor fair good excellent

Mother's emotional state during pregnancy was: poor fair good excellent

BIRTH HISTORY

Full Term Premature: _____ weeks Late: _____ weeks

How was the birth? Please state whether home/hospital, vaginal/C-section, any interventions (forceps, epidural, etc.), any complications:

_____

_____

_____

Child's birth weight: _____ Length: _____

Length of labor: _____

Check any of the following if they occurred at birth or soon after:

- ☐ Birth Defects
- ☐ Birth Injuries
- ☐ Colic
- ☐ Jaundice
- ☐ Rashes
- ☐ Seizures

GENERAL INFORMATION

Child's sleep patterns in the first year: _____

_____

Child's present sleep patterns: _____

_____

Does your child: wake early have difficulty falling asleep have nightmares/terrors

Feeding: breast-fed, How long? _____ Formula dairy / soy (please circle)

What solid foods were started prior to 6 months of age?

_____

_____

List your child's favorite foods:

List any food sensitivities/allergies:

Does your child like to cook? _____ How often? _____

Describe a typical day's diet:

Breakfast:

Lunch:

Dinner:

Snacks:

Bowel movements (quantity, color, presence of blood, mucus, undigested food):

Does your child experience any gas, bloating, vomiting, constipation or diarrhea?

Please describe the emotional climate or your home:

How many siblings does your child have (please list ages) and how they interact: