Pediatric Intake Form

Last Name: ______________________ **First Name:** _____________________ **Age:** _________
DOB:_____________
Date: _____________

List child's medical problems:
1) ____
2) ____
3) ____
4) ____

Last time blood work was done and with what doctor:____________________________

BIRTH HISTORY

Was child born full term: ☐ Yes ☐ No
Was child born premature: ☐ Yes ☐ No If yes, how early:___________
Delivery: ☐ Vaginal ☐ Caesarian
Were there complications with delivery? ☐ Yes ☐ No
If yes, please explain: ____
Were there complications with pregnancy?: ? ☐ Yes ☐ No
If yes, please explain: ____
Are there any genetic or inheritable disorders? ? ☐ Yes ☐ No
If yes, please explain: ____
Are there any growth delays? ☐ Yes ☐ No
If yes, please explain: ____
Are there any and developmental delays? ☐ Yes ☐ No
If yes, please explain: ____

List All Surgeries, Hospitalizations & Traumas — Including Date Occurred:

1. __________________________________ 4. __________________________________
2. __________________________________ 5. __________________________________
3. __________________________________ 6. __________________________________

Please Note When and Why Each of The Following:

X-rays:____ MRI/Cat Scans:____________
Ultrasounds:____ Accidents:________________

Please List All Sensitivities/Allergies/Reactions:

Drugs: ____
Foods: ____
Environment: ____

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***Please Check ALL that Apply**: **LEAVE BLANK** if you've never had the disease.*
***Check DISEASE** if you had the **DISEASE. Check IMMUNIZED** if **IMMUNIZED** with vaccinations.*

CONDITION	DISEASE	IMMUNIZED
COVID-19	☐	☐
Measles	☐	☐
Mumps	☐	☐
Rubella	☐	☐
Chickenpox	☐	☐
German measles	☐	☐
Diptheria	☐	☐
Tetanus	☐	☐
Whooping Cough	☐	☐
Hemophylis (Hib)	☐	☐
Hepatits B	☐	☐

Any Vaccination Reactions?:
____

List all CURRENT Prescription Medicines, Supplements, & Herbs You Take:

Name of Supplement/Medication	Dosage	Reason(s) for Taking Supplement/Medication	Does It Help? (Yes or No)

HEALTH HABITS
Does child participate in any individual or team sports?______________________________
EXERCISE:
How often?:____________________ What type(s)?:_________________________
How long?:_____________________________
HOBBIES: ____

SLEEP:
How long per night (hours): ______________ Frequent wakening?: ☐ Yes ☐ No
If yes, what is the reason: ____
Nightmares: ☐ Yes ☐ No ☐ Past Wake refreshed: ☐ Yes ☐ No ☐ Past
Naps during the day: ☐ Yes ☐ No ☐ Past Sleep walk: ☐ Yes ☐ No ☐ Past
Grind Teeth: ☐ Yes ☐ No ☐ Past Snore: ☐ Yes ☐ No ☐ Past

INFANT FEEDING
Was child breast-fed?: ☐ Yes ☐ No If so, for how long? ______________
Was child formula fed?: ☐ Yes ☐ No If so, what type and for how long? ______________
Has solid food been started? ?: ☐ Yes ☐ No If so, at what age was solid food began? ______________

What does child eat for the following meals?:

Breakfast: ____________________

Lunch: ____________________

Dinner: ____________________

Snacks: ____________________

How much water does child drink? ____________________

Other beverages? ____________________

Food aversions: ____________________

Food cravings: ____________________

TOXIN EXPOSURE:

Did child grow up near any refinery, or polluted area, or in home with leaded paint? If so, what sort of pollution were you exposed to?: ____________________

Has child been exposed to solvents, heavy metals, fumes, or other toxic materials?:

____

Have there been health problems experienced when new carpeting, paint, cabinets, or did other refurbishing?:

____

Sensitivities to perfumes, gasoline, or other vapors?: ____________________

Are pesticides, herbicides, other chemicals around your home? ____________________

SOCIAL LIFE

Who is child raised by, i.e. biological parents…? ____________________

History of sexual, mental/emotional, physical abuse? : ☐ Yes ☐ No ☐ Past

If so, at what age and by whom?: ____________________

FAMILY HISTORY:

	Father	Mother	Siblings	Grandparents
Age (Living)	________	________	________	________
Age (Deceased)	________	________	________	________
Reason for death	________	________	________	________
Cancer (Type)	________	________	________	________

Check Y** for **YES. CHECK N** for **NO.

	Father	Mother	Siblings	Grandparents
High blood pressure	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Heart attack/Stroke	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Heart disease	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Asthma/Allergies	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Mental illness	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Auto-immune disease	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Diabetes Mellitus	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Tuberculoses (TB)	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N

Any other conditions?: ____________________

REVIEW OF SYSTEMS

Present weight: __________ Height: __________

Weight one year ago: __________ Maximum weight & when: __________________

Maximum weight as adult & when: __________________ Ideal weight: __________

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***Please Mark ALL Symptoms that Apply**: LEAVE BLANK if you've never had the symptom.*
Check C** if you have the problem **CURRENT**. **Check P** if you had the problem in the **PAST.
Check Y** for **YES. Check N** for **NO.

Frequent Infections: ☐ Yes ☐ No ☐ Past   If yes, what types?: ____________________

Frequent Antibiotic usage: ☐ Yes ☐ No

SKIN

Rash:	☐ C	☐ P
Hives:	☐ C	☐ P
Lump:	☐ C	☐ P
Itchy:	☐ C	☐ P
Psoriasis/Eczema:	☐ C	☐ P
Skin cancer:	☐ C	☐ P

HEAD

Headache:	☐ C	☐ P
Head Injury:	☐ C	☐ P
Migraines:	☐ C	☐ P

EYES

Dry/Watery eyes:	☐ C	☐ P
Blurry vision:	☐ C	☐ P
Styes:	☐ C	☐ P
Strain:	☐ C	☐ P
Decreased hearing:	☐ C	☐ P
Double vision:	☐ C	☐ P
Discharge:	☐ C	☐ P
Dark under eyelids:	☐ C	☐ P
Itchy eyes:	☐ C	☐ P

EARS

Ear pain:	☐ C	☐ P
Ear tubes:	☐ C	☐ P
Drainage:	☐ C	☐ P
Dizziness:	☐ C	☐ P

NOSE

Frequent colds:	☐ C	☐ P
Nosebleeds:	☐ C	☐ P
Congestion:	☐ C	☐ P
Postnasal drip:	☐ C	☐ P
Nasal polyps:	☐ C	☐ P
Seasonal allergies:	☐ C	☐ P

NECK

Stiffness:	☐ C	☐ P
Swollen glands:	☐ C	☐ P
Tension:	☐ C	☐ P

MOUTH/THROAT

Canker sores:	☐ C	☐ P
Cold sores:	☐ C	☐ P
Sore throat:	☐ C	☐ P
Gum disease:	☐ C	☐ P
Cavities:	☐ C	☐ P
Loss of taste:	☐ C	☐ P
Hoarseness:	☐ C	☐ P

CARDIOVASCULAR

Painful breathing:	☐ C	☐ P
Rheumatic Fever:	☐ C	☐ P
Low blood pressure:	☐ C	☐ P
Murmurs:	☐ C	☐ P
Arrhythmias:	☐ C	☐ P
Palpitations:	☐ C	☐ P
Edema:	☐ C	☐ P
Shortness of breath lying down:	☐ C	☐ P
Chest pain:	☐ C	☐ P

URINARY

Frequent urination	☐ C	☐ P
Pain with urination:	☐ C	☐ P
Discharge/Blood:	☐ C	☐ P
Urgency:	☐ C	☐ P

ENDOCRINE

Change in appetite:	☐ C	☐ P
Diabetes:	☐ C	☐ P
Heat intolerance:	☐ C	☐ P
Cold intolerance:	☐ C	☐ P
Thyroid problems:	☐ C	☐ P
Difficulty maintaining weight:	☐ C	☐ P

RESPIRATORY

Cough:	☐ C	☐ P
Shortness of breath with exertion:	☐ C	☐ P
Tuberculosis:	☐ C	☐ P
Bronchitis:	☐ C	☐ P
Pneumonia:	☐ C	☐ P
Asthma:	☐ C	☐ P
Wheezing:	☐ C	☐ P

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GASTROINTESTINAL

Heartburn:	☐ C	☐ P
Bowel movement (BM) frequency:	___________	
Indigestion:	☐ C	☐ P
Recent change in BM:	☐ C	☐ P
Bloating:	☐ C	☐ P
Diarrhea:	☐ C	☐ P
Constipation:	☐ C	☐ P
Nausea:	☐ C	☐ P
Ulcer:	☐ C	☐ P
Vomiting:	☐ C	☐ P
Pancreatitis:	☐ C	☐ P

HEMATOLOGIC

Anemia:	☐ C	☐ P
Easy bruising:	☐ C	☐ P
Easy bleeding:	☐ C	☐ P
Transfusions:	☐ C	☐ P

MUSCULOSKELETAL

Weakness:	☐ C	☐ P
Arthritis:	☐ C	☐ P
Stiffness:	☐ C	☐ P
Leg cramps:	☐ C	☐ P
Tremors:	☐ C	☐ P
Joint pain:	☐ C	☐ P
Scoliosis:	☐ C	☐ P

MALE

Genital malformation:	☐ C	☐ P
Testicular pain or swelling:	☐ C	☐ P
Hernia:	☐ C	☐ P
Discharge:	☐ C	☐ P

FEMALE

Menstruation:	☐ C	☐ P
Age periods began:	___________	
How long periods last:	___________	
How often?:	___________	

NERVOUS

Paralysis:	☐ C	☐ P
Tingling/Numbness:	☐ C	☐ P
Seizures:	☐ C	☐ P
Scoliosis:	☐ C	☐ P

MENTAL/EMOTIONAL

Tantrums	☐ C	☐ P
Depression:	☐ C	☐ P
Anger/Irritability:	☐ C	☐ P
Suicidal:	☐ C	☐ P
Anxiety:	☐ C	☐ P
Fear/Panic:	☐ C	☐ P