

# PEDIATRIC INTAKE & HISTORY

## PATIENT INFORMATION

Patient Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Email \_\_\_\_\_  
Sex  M  F Age \_\_\_\_\_ Birthday \_\_\_\_\_

Mother's Name \_\_\_\_\_  
Mother's Occupation \_\_\_\_\_  
Mother's Phone \_\_\_\_\_  
Mother's Email \_\_\_\_\_

Father's Name \_\_\_\_\_  
Father's Occupation \_\_\_\_\_  
Father's Phone \_\_\_\_\_  
Father's Email \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Contact Number \_\_\_\_\_

**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)

<input type="checkbox"/> Back/Other Pain	<input type="checkbox"/> Gestational Diabetes	<input type="checkbox"/> Pre/Eclampsia	<input type="checkbox"/> Strep B	<input type="checkbox"/> Nausea/Vomiting
<input type="checkbox"/> Pre-Term	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Swelling	<input type="checkbox"/> Other (please describe) _____	

\_\_\_\_\_

## BIRTH HISTORY

Type of birth (check all that apply):

<input type="checkbox"/> Hospital	<input type="checkbox"/> Birth Center	<input type="checkbox"/> Home	<input type="checkbox"/> Normal / Vaginal	<input type="checkbox"/> Breech
<input type="checkbox"/> Cesarean	<input type="checkbox"/> Scheduled/Induced	<input type="checkbox"/> Epidural		

Problems during labor / delivery? \_\_\_\_\_  
\_\_\_\_\_

<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Congenital Anomalies	<input type="checkbox"/> Failure to Thrive	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Meconium
<input type="checkbox"/> Respiratory Distress	<input type="checkbox"/> Extended Hospitalization	<input type="checkbox"/> 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                       Rubeola  
 Mumps                               Rubella                       Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?:

- |  |   |  |   |  |
|--|---|--|---|--|
| <input type="checkbox"/> Allergies           | <input type="checkbox"/> Broken Bones         | <input type="checkbox"/> Digestive Issues<br>(constipation/diarrhea) | <input type="checkbox"/> Hypertension                     | <input type="checkbox"/> Orthopedic Problems |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Chronic Ear Aches    | <input type="checkbox"/> Dizziness                                   | <input type="checkbox"/> Juvenile<br>Rheumatoid Arthritis | <input type="checkbox"/> Paralysis           |
| <input type="checkbox"/> Arm Problems        | <input type="checkbox"/> Colds/Flu            | <input type="checkbox"/> Fainting                                    | <input type="checkbox"/> Joint Problems                   | <input type="checkbox"/> Poor Appetite       |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Colic                | <input type="checkbox"/> Headaches                                   | <input type="checkbox"/> Leg Problems                     | <input type="checkbox"/> Ruptures/Hernias    |
| <input type="checkbox"/> Back Aches          | <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Heart Trouble                               | <input type="checkbox"/> Neck Problems                    | <input type="checkbox"/> Sinus Trouble       |
| <input type="checkbox"/> Bed Wetting         | <input type="checkbox"/> Delayed Speech       | <input type="checkbox"/> Hyperactivity                               | <input type="checkbox"/> Neuritis                         | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Diabetes             |  |   | <input type="checkbox"/> 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: \_\_\_\_\_

Childrens' 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: \_\_\_\_\_