PEDIATRIC INTAKE FORM

Child's Name: ________________________ Today's Date: ______________
Child's Age: _______ Date of Birth: ___________ Child's Height: _________ Weight: ___________
Male ❒ Female ❒ Grade Level: _________
How did you hear about us? (Referred by)______________________________
Name and relation of individual who is filling out this form: ______________________
Has any other family member been a client at the clinic?_____________________

*** Use final page if additional space is needed to answer any questions ***

Parents/Guardians

Name and relation to child: ________________________________
Phone: (home) ______________ (work) ____________(cell) ______________
Address: ____
Email (for appointment reminder): ____________________________

Name and relation to child: ________________________________
Phone: (home) ______________ (work) ____________ (cell)______________
Address: ____

Whom does the child live with? ____________________________

Child's Other Health Care Providers

Provider's name: ___________________________Phone: ______________
Designation/type of practice:______________________________
Last seen for what condition/date: __________________________

Provider's name: ___________________________Phone: ______________
Designation/type of practice:______________________________
Last seen for what condition/date: __________________________

Health Concerns

Please list the child's health concerns in order of importance.
1. Primary health concern:______________________________
When did it begin?____________________________________
What do you think might be causing this condition? ____________________

____
How has it been treated in the past and what was the effectiveness? ____________________
____

2. Secondary health concern: ____
When did it begin? ____
What do you think might be causing this condition? ___________________________
____
How has it been treated in the past and what was the effectiveness? ____________________
____
Other health concerns:
3. ____
4. ____
5. ____

Prenatal Health and History

How was the emotional and physical health of the parents at the time of conception?
Mother: ____
Father: ____
How was the emotional and physical health of the mother during pregnancy? ___________
____
How was the mother's diet during pregnancy? ____________________________________
Describe any previous pregnancies, miscarriages, births and complications? _____________
____
What was mother's age at the time of the child's birth? _______________________________
Did mother experience any of the following during pregnancy?
❒ Bleeding ❒ High blood pressure ❒ Nausea ❒ Vomiting
❒ Diabetes ❒ Thyroid problems ❒ Physical or emotional trauma
❒ Illness ❒ Other: ______________________________
Did the mother use any of the following during pregnancy?
❒ Tobacco ❒ Alcohol ❒ Recreational drugs ❒ Prescription medications
❒ Over-the-counter medications ❒ Vitamins and/or supplements
Please specify ____
Any medical tests used during pregnancy? ❒ Ultrasound ❒Amniocentesis
❒ Chorionic Villi Sampling ❒ Triple Screen ❒ Maternal Serum Screening

Birth History

Term length: ❒ Pre-term (37 weeks or less): ________ weeks

❒ Full-term (38-42 weeks): _________ weeks
❒ Post-term (more than 42 weeks): _________ weeks

Location of birth: ❒ Hospital ❒ Home ❒ Birthing Center ❒ Other: ____________________

Delivery was: ❒ Vaginal ❒ Scheduled C-section ❒ Emergency C-section

❒ Induced labor/Pitocin ❒ Forceps/Vacuum extraction ❒ Epidural/Anesthesia

❒ Episiotomy ❒ Other: ___________________________________

Any complications before/during delivery (e.g., breech delivery)? __________________________

____

Length of labor: _________ Weight of infant at birth:___________________________________

APGAR score (0 to 10): 1minute ______ 5 minutes _________

Did the child experience any of the following at or shortly after birth?

❒ Jaundice ❒ Rashes ❒ Seizures ❒ Birth injuries/defects ❒ Infections

❒ Difficulties with feeding ❒ Other____

Dietary History

❒ Breastmilk exclusively until age _____ ❒Breastmilk with supplemental formula

❒ Not breastfed

❒ Started supplementary foods age _______ Weaned from the breast age _______

❒ Formula (what types/when started) ____

❒ Other: ____

Did the infant have any colic or reflux, or other reactions to what was fed? ________________

____

Please describe foods introduced and what age, together with any reactions noted:

0-6 months ____

6-12 months____

12-18 months ____

18+ months____

Please list any (known or suspected) food allergies or intolerances:

____

Any dietary restrictions (vegetarian/vegan, religious, etc.)?

____

Eating habits (good appetite, picky eater, tastes, textures, etc.)?

____

Medical History

Has the child ever experienced any of the following illnesses?

❒ Rubella ❒ Mumps ❒ Whooping Cough ❒ Asthma

❒ Measles ❒ Chickenpox ❒ Scarlet Fever ❒ Polio

❒ Rheumatic Fever ❒ Other: ___________________________________

Has the child received any of the following vaccinations?
❒ DPT ❒ MMR ❒ HIB ❒ Polio ❒ TB ❒ Flu
❒ Smallpox ❒ Pneumococcus ❒ Chickenpox ❒ Hepatitis
❒ Other: ____
Did the child have any reactions following vaccination? ___________________
____

Has the child ever been hospitalized? ❒Yes ❒No
If yes, for what reason? For how long? ___________________________
____

Has the child had any of the following tests? Please explain when and why they were taken:
❒ CT Scan/X-ray/MRI ___________________
❒ Electroencephalogram ___________________
❒ Psychological evaluation ___________________
❒ Hearing evaluation___________________
❒ Speech/Language evaluation ___________________
Has the child ever had any physical or emotional traumas? ___________________
____
____

Please circle: Y = a condition your child has now. N = never had. P = has had in the past, even as a baby.

Condition				Condition			
Hives or Rashes	Y	N	P	Bedwetting	Y	N	P
Eczema	Y	N	P	Nervous or moody	Y	N	P
Acne	Y	N	P	Cries easily	Y	N	P
Frequent colds	Y	N	P	Unusual fears	Y	N	P
High fever	Y	N	P	Sensitivity to heat or cold	Y	N	P
Cough/Croup/Wheezing	Y	N	P	Stomach aches	Y	N	P
Bronchitis/Pneumonia	Y	N	P	Gas/colic	Y	N	P
Frequent sore throats	Y	N	P	Diarrhea	Y	N	P
Frequent headaches	Y	N	P	Vomiting	Y	N	P
Bleeding gums or nose	Y	N	P	Constipation	Y	N	P
Allergies	Y	N	P	Loss of appetite	Y	N	P
Dizzy spells	Y	N	P	Body/breath odor	Y	N	P
Ear infections (how many)	Y	N	P	Jaundice	Y	N	P
Hearing loss	Y	N	P	Anemia	Y	N	P
Frequent urination	Y	N	P	Bleeding/Bruising	Y	N	P
Burning or bloody urine	Y	N	P	Fatigue	Y	N	P

Night sweats	Y	N	P	Joint pains	Y	N	P
Heart murmur	Y	N	P	Developmental issues	Y	N	P

Medication History:
❒ Aspirin ❒ Tylenol ❒ Ibuprofen/Advil ❒ Antibiotics ❒ Decongestant
❒ Anti-histamine ❒ Topical steroids ❒ Inhalers ❒ Asthma meds
❒ Aspirin or Tylenol specifically for fever ❒ Others ______________________
Please list any medications and/or supplements the child is currently taking: ______________
____
____
Does the child have any known drug allergies? ❒Yes ❒No
If yes, please list drug allergies: ____

Health and Development

How was the child's health in the first year? ____
____
How is the child's health now? ____
____
At what age did the child first: Sit up ________ Crawl ________ Walk ________ Talk _______
How was toilet training? ____
Was teething early, late or typical? Difficult? ____

Sleep Patterns

What time does the child usually go to bed?____
What time does the child usually wake in the morning? __________________________________
Does the child nap during the day? ❒Yes ❒No What time(s) do they nap? _____________
Does the child have nightmares? ❒Yes ❒No Please describe? ________________________
Does the child have any problems associated with sleeping? ❒Yes ❒No
If yes, what kind of trouble do they have (e.g., trouble falling asleep, trouble waking up, etc.)? ____

Social Patterns

Is the child in: ❒School ❒Daycare ❒Home care ❒Other: __________________________
How would you describe the child's behavior at school?_______________________________
____
____

How would you describe the child's behavior at home?______________________________

What are the child's interests and favorite activities? ______________________________

What recreational activities is the child involved in? ______________________________

How would you describe the child's temperament/personality? ______________________________

Is there anything that you would want to change?______________________________

How much and how often does the child exercise? ______________________________

How much television does the child watch? _______ hours a day/week.
How often does the child read, **or** How often does someone read to the child?
❒ Daily ❒ Several times a week ❒Weekly ❒ Less than weekly

Family History

Please indicate if a close relative (parent, grandparent, sibling) has any of the following:

Condition	Relative	Condition	Relative
❒ Allergies/Hay fever		❒ Eczema/Psoriasis	
❒ Anemia		❒ Food Intolerances	
❒ Arthritis		❒ Heart Disease	
❒ Asthma		❒ High Blood Pressure	
❒ Autoimmune Disease		❒ Juvenile Arthritis	
❒ Birth Defects		❒ Kidney Disease	
❒ Bleeding Disorder		❒ Mental Illness	
❒ Cancer		❒ Seizures	
❒ Depression/Anxiety		❒ Stroke	
❒ Diabetes		❒ Tuberculosis	
❒ Other:		❒ Other:	

❒ I don't know the family medical history

Do either of the parents of the child have a chronic illness? ❒Yes ❒No
If yes, please describe:______________________________

Environment

Are there any pets in the home? ❒ Yes ❒No
If yes, what type and how many? ____
____

Does anyone in the child's household smoke? ❒Yes ❒No
How is the child's home heated?____
Do you know of any toxins or other hazards that the child is regularly exposed to? ❒yes ❒no
If yes, please describe:____
____

How would you describe the emotional climate of the child's home? _________________
____

Does the child have any known environmental or chemical sensitivities (e.g., perfumes, detergents, odors, soaps, etc.)? ____
____

Is there anything that you feel is important that has not been covered?_______________
____
____
____

Diet Diary:

On the following page, you will find a Diet Diary. Please list, in the spaces provided, every food item that the child puts into their mouth for a 7 day period. Please take note of any physical symptom or sensitivities that they may experience during this exercise and note them in the 'notes' section provided.

Diet Diary

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unch							
inner							
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