

# PEDIATRIC INTAKE & HISTORY



## PATIENT INFORMATION

Patient Name _____	Mother's Name _____
Address _____	Mother's Occupation _____
City _____ State _____ Zip Code _____	Mother's Phone _____
Home Phone _____	Mother's Email _____
Cell Phone _____	
Email _____	Father's Name _____
Sex <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Birthday _____	Father's Occupation _____
<b>IN CASE OF EMERGENCY, CONTACT</b>	Father's Phone _____
Name _____	Father's Email _____
Relationship _____	<b>Who may we thank for referring you?</b>
Contact Number _____	_____

## 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  Rubioli  
 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"/>   | <input type="checkbox"/>                                    | <input type="checkbox"/> Walking Problems    |
| <input type="checkbox"/>                     | <input type="checkbox"/>                      | <input type="checkbox"/>   | <input type="checkbox"/>                                    | <input type="checkbox"/>                     |

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: \_\_\_\_\_

Children's 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: \_\_\_\_\_