

PEDIATRIC INTAKE & HISTORY



PATIENT INFORMATION

Patient Name _____	Parent's Name _____
Address _____	Parent's Occupation _____
City _____ State _____ Zip _____	Parent's Phone _____
Home Phone _____	Parent's Email _____
Cell Phone _____	
Email _____	Parent's Name _____
Sex ☐ M ☐ F Age _____ Birthday _____	Parent's Occupation _____
Pediatrician	Parent's Phone _____
Name _____	Parent's Email _____
Office _____	Who may we thank for referring you?
Contact Number _____	_____

HOW CAN WE HELP YOUR CHILD?

☐ Wellness Checkup ☐ Other: _____

If your child is already experiencing a symptom, please describe it:

Health Goals for your child:

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)

☐ Back/Other Pain	☐ Gestational Diabetes	☐ Pre/Eclampsia	☐ Strep B	☐ Nausea/Vomiting
☐ Pre-Term	☐ Fatigue	☐ Swelling	☐ Other (please describe) _____	

BIRTH HISTORY

Type of birth (check all that apply):

☐ Hospital	☐ Birth Center	☐ Home	☐ Normal / Vaginal	☐ Breech
☐ Cesarean	☐ Scheduled/Induced	☐ Epidural	☐ Forceps/Vacuum	

Problems during labor / delivery? _____

How long were you in labor? _____ How long were you pushing? _____

☐ Antibiotics	☐ Congenital Anomalies	☐ Failure to Thrive	☐ Jaundice	☐ Meconium
☐ Respiratory Distress	☐ Extended Hospitalization	☐ Other _____		

Birth Trauma? Bruises Cord around Neck Stuck in canal Fast/long Odd shaped head

GROWTH & DEVELOPMENT

Infant feeding: ☐ Breast ☐ Bottle ☐ Formula Mom's Diet: _____

Difficulty with lactation or latching? _____ If yes, which breast: _____ Lip or Tongue Tie: _____

Number of hours of sleep each night: _____ Difficulty falling or staying asleep? _____ Quality of sleep: _____

Does your child experience reflux? _____ If yes, how many times per day? _____

Does it occur: ☐ After feeding ☐ Between feeding ☐ During sleep ☐ Anytime

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 ☐ Rubiola
☐ Mumps ☐ Rubella ☐ Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?: Round of Antibiotics: _____

☐ Allergies ☐ Broken Bones ☐ Digestive Issues (constipation/diarrhea) ☐ Hypertension ☐ Orthopedic Problems
☐ Anemia ☐ Chronic Earaches ☐ Juvenile / Rheumatoid Arthritis ☐ Paralysis
☐ Arm Problems ☐ Colds/Flu ☐ Dizziness ☐ Poor Appetite
☐ Asthma ☐ Colic ☐ Fainting ☐ Joint Problems ☐ Ruptures/Hernias
☐ Back Aches ☐ Convulsions/Seizures ☐ Headaches ☐ Leg Problems ☐ Sinus Trouble
☐ Bed Wetting ☐ Delayed Speech ☐ Heart Trouble ☐ Neck Problems ☐ Tuberculosis
☐ Behavioral Problems ☐ Diabetes ☐ Hyperactivity ☐ Neuritis ☐ 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)

Screen Time:

Diet:

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: I hereby authorize this clinic and its doctor(s) to administer care as they deem necessary.

Signed: _____ Date: _____