Pediatric Intake & History

Patient Information

Patient name: _____
Address: _____
City: _____State: _____Zip:_____
Home Phone: _____
Cell Phone: _____
Email: _____
Sex: M F Age _____
Date of Birth: _____
IN CASE OF EMERGENCY, CONTACT:
Name: _____
Relationship: _____
Contact number: _____

Mother's name: _____
Mother's occupation: _____
Mother's phone: _____
Mother's email: _____

Father's name: _____
Father's occupation: _____
Father's phone: _____
Father's email: _____

Who may we thank for referring you?
_____

How Can We Help Your Child?

Wellness visit Y N Other: _____
If your child is already experiencing symptom(s), please describe them here:
_____
_____
_____
Has your child been treated for any emergencies? Y N
Please describe:
_____
_____

Pregnancy History

Did the mother experience any complications during the pregnancy with this child? (Circle all that apply)
Back/Other Pain Gestational Diabetes Preeclampsia Strep B Nausea
Pre-term labor Fatigue Swelling Other: _____
Medications taken by the mother during pregnancy: _____
Reason:_____

Birth History

Type of birth (Circle all that apply): Hospital Birth Center Home
Vaginal Cesarean Breech Induced Epidural
Problems during labor & delivery: _____
Antibiotics Congenital Anomalies Failure to Thrive Jaundice Meconium
Respiratory Distress Extended Hospitalization 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: _____

Sit unsupported: _____ Stand: _____ Walk unsupported: _____

Childhood Diseases, Illnesses & Vaccinations

Has your child had (circle all that apply)?

Chicken Pox Measles Rubeola

Mumps Rubella Pertussis/Whooping Cough

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

Allergies	Broken Bones	Digestive Issues	Hypertension	Orthopedic problems
Anemia	Chronic ear problems	Arm problems	Colds/Flu	Dizziness
Asthma	Poor Appetite	Fainting	Colic	Joint problems
Hernias	Back aches	Seizures	Headaches	Leg problems
Bed wetting	Sinus trouble	Acid reflux	Delayed speech	Heart trouble
Diabetes	Neck problems	Behavior issues	Hyperactivity	Walking/crawling problems

Have you vaccinated your child (circle)?

No Yes As scheduled Delayed schedule

Allergies, Medications, Surgeries & Family History

Allergies (list)

_____

_____

Medications (list)

_____

_____

Surgeries (list)

_____

_____

`

Family History (illnesses)

_____

_____

Extra Information about Mother & Siblings

How many children do you have? _____

Children's ages: _____

Childrens' health concerns: _____

_____

Number of pregnancies: _____

Are you pregnant? Y NDue date:_____

Health concerns regarding current 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.

Signed: _____ Witnessed: _____

Date: _____