



Pediatric Intake Form

Last Name: _____ **First:** _____ **Age:** _____
DOB: _____
Date: _____

List child's medical problems:

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Last time blood work was done and with what doctor: _____

BIRTH HISTORY

Was child born full term: Y N
 Was child born premature: Y N If yes how early: _____
 Vaginal or Caesarian delivery?
 Were there complications with delivery? Y N if yes, please explain:

 Were there complications with pregnancy?: Y N If yes, please explain:

 Are there any genetic or inheritable disorders? Y N If yes, please explain: _____

 Are there any growth delays? Y N If yes, please explain: _____

 Are there any and developmental delays? If yes please explain: _____

FAMILY HISTORY

	Father	Mother	Siblings	Grandparents
Age if living	_____	_____	_____	_____
Age when died	_____	_____	_____	_____
Reason for death	_____	_____	_____	_____
Cancer (type)	_____	_____	_____	_____
Heart Attack/stroke	Y N	Y N	Y N	Y N
Heart disease	Y N	Y N	Y N	Y N
Asthma/allergies	Y N	Y N	Y N	Y N
Mental illness	Y N	Y N	Y N	Y N
TB	Y N	Y N	Y N	Y N
Auto-immune disease	Y N	Y N	Y N	Y N
Diabetes Mellitus	Y N	Y N	Y N	Y N

List All Surgeries and Hospitalizations—including date occurred:

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

Please Note When and Why Each of the Following:

X-rays: _____
 MRI/Cat Scans: _____
 Ultrasounds: _____
 Accidents: _____

Please List All Sensitivities/Allergies/Reactions

Drugs: _____
 Foods: _____
 Environment: _____

Did you have the following Disease (D), Get Immunized for it (I), or Neither (N):

Measles:	D I N	Diphtheria:	D I N
Mumps:	D I N	Tetanus:	D I N
Rubella:	D I N	Whooping Cough:	D I N
Chickenpox:	D I N	Hemophilus (Hib):	D I N
German Measles:	D I N	Hepatitis B:	D I N

Any vaccination reactions: _____

List all Prescription Medicines, Supplements, & Herbs Taken: INCLUDE DOSAGE

Exercise:

How often?: _____ What type?(s): _____
 For How long: _____

Hobbies: _____

Sleep:

How long per night: _____ frequent waking? Y N if yes, what is the reason?: _____

Nightmares: Y N P Wake refreshed: Y N P Naps during the day: Y N P
 Sleep walk: Y N P Grind Teeth: Y N P Snore: Y N P

Infant Feeding:

Was child breast feed? Y N If so, for how long? _____
 Was child formula feed? Y N If so, what type and for how long? _____
 Has solid food been started? Y N If so, at what age was solid food began?

Typical Days Diet:

How much water dose child drink? _____
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Food aversions: _____
Food cravings: _____

Toxin Exposure:

Did child grow up near any refinery, or polluted area, or in home with leaded paint? If so, what sort of pollution were you exposed to?: _____
Have child been exposed to solvents, heavy metals, fumes, or other toxic materials?: _____
Have there been health problems experienced when new carpeting, paint, cabinets, or did other refurbishing was performed?: _____
Is there sensitive to perfumes, gasoline, or other vapors?: _____
Are pesticides, herbicides, or other chemicals used around your home? _____

Social Life:

Quality of most significant relationship? _____
History of sexual, mental/emotional, physical abuse?: Y N P
If so, at what age and by whom?: _____

REVIEW OF SYSTEMS

Present Weight: _____ Weight one year ago: _____
Height: _____ Maximum weight and when: _____
Minimum Weight as adult and when: _____
Ideal Weight: _____

Regarding the Next Section: Please Circle Y if you have the problem now, N if you've never had the problem, P if you had the problem in the PAST.
If two symptoms are listed, circle the one (s) you have.

Frequent Infections: Y N P If yes, what types: _____
Frequent Antibiotic usage: Y P

SKIN

Rash: Y N P	Hives: Y N P
Lump: Y N P	Itchy: Y N P
Psoriasis/eczema: Y N P	Cancer: Y N P

HEAD

Headache: Y N P
Head Injury: Y N P
Migraine: Y N P

EYES

Dry/Watery: Y N P
Blurry vision: Y N P
Itchy: Y N P
Styes: Y N P
Strain: Y N P

EARS

Ear Pain: Y N P
Ear tubes: Y N P
Drainage: Y N P
Dizziness: Y N P

Decreased Hearing: Y N P
Double vision: Y N P
Discharge: Y N P
Dark under eyelid: Y N P

NOSE

Frequent colds: Y N P
Nosebleeds: Y N P
Congestion: Y N P
Post nasal drip: Y N P
Polyps: Y N P
Seasonal allergies: Y N P

MOUTH/THROAT

Canker sores: Y N P
Cold sores: Y N P
Sore throat: Y N P
Gum disease: Y N P
Cavities: Y N P
Loss of taste: Y N P
Hoarseness: Y N P

NECK

Stiffness: Y N P
Swollen glands: Y N P
Full movement: Y N P
Tension: Y N P

RESPIRATORY

Cough: Y N P
Shortness of breath with exertion: Y N P
Tuberculosis: Y N P
Bronchitis: Y N P
Pneumonia: Y N P
Asthma: Y N P
Wheezing: Y N P

CARDIOVASCULAR

Painful breathing: Y N P
Rheumatic Fever: Y N P
Low blood pressure: Y N P
Murmurs: Y N P
Arrhythmias: Y N P
Palpitations: Y N P
Edema: Y N P
Shortness of breath lying down: Y N P
Chest pain: Y N P

GASTROINTESTINAL

Heartburn: Y N P
Bowel movement frequency: _____
Colic: Y N P
Indigestion: Y N P
Recent change in BM: Y N P
Bloating: Y N P
Diarrhea: Y N P
Constipation: Y N P
Nausea: Y N P
Ulcer: Y N P
Vomiting: Y N P
Pancreatitis: Y N P

URINARY

Frequent infections: Y N P
Pain with urination: Y N P
Discharge/blood: Y N P
Urgency: Y N P

ENDOCRINE

Change in Appetite: Y N P
Diabetes: Y N P
Heat/Cold intolerance: Y N P
Thyroid problem: Y N P
Difficulty maintaining weight: Y N P

HEMATOLOGIC

Anemia: Y N P
Easy bruising/bleeding: Y N P
Transfusions: Y N P

MALE

Genital malformation: Y N P
Testicular pain/swelling: Y N P
Hernia: Y N P
Discharge: Y N P

FEMALE

Menstruation: Y N P
Age periods began: _____
How long periods last: _____
How often periods occur: _____

MUSKULOSKELETAL

Weakness: Y N P
Arthritis: Y N P
Stiffness: Y N P
Leg cramps: Y N P
Tremors: Y N P
Pain: Y N P
Scoliosis : Y N P

NERVOUS

Paralysis: Y N P
Tingling/numbness: Y N P
Seizures: Y N P
Fainting: Y N P

MENTAL/EMOTIONAL

Tantrums: Y N P
Depression: Y N P
Suicidal: Y N P

Anger/irritability: Y N P
Anxiety: Y N P
Fear/Panic: Y N P