

Pediatric Intake Form

Patient name _____ Date of Birth _____ Age _____
 Parent/Guardian name/s _____ Phone number _____
 Address _____
 Child's primary care provider _____ Phone number _____
 Reasons for your visit _____

Pregnancy and birth

Place of birth _____
 Child is yours by: (circle one) birth/adoption/stepchild/other
 Please note any medical problems associated with pregnancy, including fertility Issues.

Describe any interventions at birth including caesarean section.

Gestational age at birth: _____ Birth weight: _____ Birth length: _____
 Location of birth: (circle one) home / hospital / birthing center
 Health issues during newborn period _____

Child breast fed: (circle one) Y N If yes, how long? _____
 When was solid food introduced? _____
 Food or feeding problems: _____

Vaccination History

MMR Y N Age: _____ DPT Y N Age: _____ Hib Y N Age: _____
 Hep B Y N Age: _____ Chicken Pox Y N Age: _____ Polio Y N Age: _____
 Others: _____
 Please note any adverse reactions to vaccines: _____

Social History

Are both parents living in the home? Y N
 Names and ages of siblings, if any: _____

 Pets: _____

Recent travel: _____

Recent life changes: _____

Does your child attend school? (circle one) Y N If yes, what grade? _____

Any concerns about school? _____

Sports, activities: _____

Please list any concerns you have about your child's social interactions.

Medical History

Past and current medications: _____

Supplements: _____

Illnesses: _____

Surgeries or other trauma: _____

Typical diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

Please circle any of the conditions listed below that are a concern for your child:

Appetite: poor / excessive

Headaches

Thirst: little / excessive

Poor concentration

Unusual sweating

Frequent colds

Asthma

Energy level: low / excessive

Sleep: poor / excessive sleepiness / night terrors

Bowel movements: constipation / loose stools / diarrhea

Urination: frequent / painful / bedwetting

Seizures

Skin problems: Specify: _____

Allergies: _____

Emotional problems: _____

Other: _____

Family Health History

Please note which family member has any of the following:

Issue	(check)	Family member
Heart Disease		
Cancer		
Thyroid Disorder		
Hepatitis		
Allergies		
Auto-Immune Disease		
Asthma		
Congenital Disorders		
Seizures		
Mental Illness		
Neurological Disorders		
Other (please specify)		