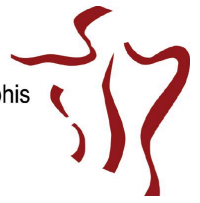


# PEDIATRIC INTAKE & HISTORY



## PATIENT INFORMATION

Patient Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_ State \_\_\_\_\_  
Cell Phone (if applicable) \_\_\_\_\_  
Email (if applicable) \_\_\_\_\_  
Sex  M  F Age \_\_\_\_\_ Birthday \_\_\_\_\_

Mother's Name \_\_\_\_\_  
Mother's Occupation \_\_\_\_\_  
Mother's Phone \_\_\_\_\_  
Mother's Email \_\_\_\_\_

Father's Name \_\_\_\_\_  
Father's Occupation \_\_\_\_\_  
Father's Phone \_\_\_\_\_  
Father's Email \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Contact Number \_\_\_\_\_

**Who may we thank for referring you?**  
\_\_\_\_\_

## 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 for this symptom or any other reason?  Yes  No

Please describe: \_\_\_\_\_  
\_\_\_\_\_

## MOTHER'S 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

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: \_\_\_\_\_

Stand: \_\_\_\_\_ Sit unsupported: \_\_\_\_\_ Walk unsupported: \_\_\_\_\_

## CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Has your child had (check all that apply)?:

- Chicken Pox                       Measles                       Rubeola  
 Mumps                               Rubella                       Pertussis/Whooping Cough

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

- Allergies                       Broken Bones                       Digestive Issues (constipation/diarrhea)                       Hypertension                       Orthopedic Problems  
 Anemia                       Chronic Ear Aches                       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)

\_\_\_\_\_  
\_\_\_\_\_

## SIBLINGS

How many children do you have? \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_

Childrens' ages: \_\_\_\_\_

Are you currently pregnant?     No     Yes, I'm due: \_\_\_\_\_

Childrens' health concerns: \_\_\_\_\_

Health concerns regarding this pregnancy? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I acknowledge that all information provided is accurate. I hereby authorize this clinic and its doctor(s) to administer care as they deem necessary to my child. I authorize the utilization of this application or copies for the purpose of processing health insurance claims and effecting payments.**

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Staff: \_\_\_\_\_