

# PEDIATRIC INTAKE & HISTORY

## PATIENT INFORMATION

Patient Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Email \_\_\_\_\_  
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?  Yes  No  
Please describe: \_\_\_\_\_  
\_\_\_\_\_

## PREGNANCY HISTORY

Did you experience any complications during your pregnancy? (check all that apply)

<input type="checkbox"/> Back/Other Pain	<input type="checkbox"/> Gestational Diabetes	<input type="checkbox"/> Pre/Eclampsia	<input type="checkbox"/> Strep B	<input type="checkbox"/> Nausea/Vomiting
<input type="checkbox"/> Pre-Term	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Swelling	<input type="checkbox"/> Other (please describe) _____	

\_\_\_\_\_

## BIRTH HISTORY

Type of birth (check all that apply):

<input type="checkbox"/> Hospital	<input type="checkbox"/> Birth Center	<input type="checkbox"/> Home	<input type="checkbox"/> Normal / Vaginal	<input type="checkbox"/> Breech
<input type="checkbox"/> Cesarean	<input type="checkbox"/> Scheduled/Induced	<input type="checkbox"/> Epidural		

Problems during labor / delivery? \_\_\_\_\_  
\_\_\_\_\_

<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Congenital Anomalies	<input type="checkbox"/> Failure to Thrive	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Meconium
<input type="checkbox"/> Respiratory Distress	<input type="checkbox"/> Extended Hospitalization	<input type="checkbox"/> 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: \_\_\_\_\_

Children's' Ages: \_\_\_\_\_

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

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

Health concerns regarding this 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/ward.

Signed: \_\_\_\_\_ Witnessed: \_\_\_\_\_ Date: \_\_\_\_\_