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PEDIATRIC INTAKE FORM (6-12 years)

Name: _____ Date: _____

Age: ____ Date of Birth: _____/_____/_____ Female: _____ Male: _____

Mother's name: _____ Father's name:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone # (home): (_____)_____ Parent's # (work): (_____)_____

Parent's e-mail address: _____ Care Card Number: _____

How did you hear about our clinic? _____

HEALTH HISTORY QUESTIONNAIRE

What are your child's most important health problems? List as many as you can in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Does your child have a contagious disease at this time? Y N
If yes, what? _____

Previous Illnesses

Rheumatic fever	Y N	German measles	Y N
Chicken pox	Y N	Measles	Y N
Tonsillitis	Y N	approx. number	_____
Ear infections	Y N	approx. number	_____
Other	Y N	list	_____

Has your child had any of the following tests? When Where

Electroencephalogram (EEG)
.....
Psychological evaluation
.....
Hearing tests
.....
Speech/Language tests
.....

Hospitalizations/ Surgeries/ Injuries

What hospitalizations, surgeries or injuries has your child had?

_____
_____

Welcome! We are honored to be of service for you and your child!

Immunizations

Polio	Y N	Pertussis	Y N
Tetanus shot	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Influenza	Y N
Any adverse reactions?	Y N	If yes, what ? _____	

Allergies

Is your child hypersensitive or allergic to:
Any drugs?_____
Any foods? _____
Any environmentals?_____
Breast fed? _____ how long? _____ Formula? ____ milk / soy ____

Typical Food Intake

Breakfast:_____
Lunch: _____
Dinner: _____
Snacks: _____
To Drink: _____

Please list **any** prescription medications, over the counter medications, vitamins or other supplements your child is taking:

1) _____ 5) _____
2) _____ 6) _____
3) _____ 7) _____
4) _____ 8) _____

REVIEW OF SYSTEMS

Y = a condition now **P** = significant problem in the past **N** = never had

MENTAL/ EMOTIONAL

Mood Swings	Y	P	N	Anxiety/nervousness	Y	P	N
Irritability	Y	P	N	Cries easily	Y	P	N
Hyperactivity	Y	P	N	Unusual fears	Y	P	N
Introvert/extrovert	Y	P	N	Sleep problems	Y	P	N
Motion/car sickness	Y	P	N	Nightmares	Y	P	N

ENDOCRINE

Heat/cold intolerance	Y	P	N	Fatigue	Y	P	N
Excessive thirst	Y	P	N	Excessive hunger	Y	P	N
Low blood sugar	Y	P	N	High blood sugar	Y	P	N

SKIN

Rashes	Y	P	N	Eczema, Hives	Y	P	N
Acne, Boils	Y	P	N	Itching	Y	P	N

HEAD

Headaches	Y	P	N	Head Injury	Y	P	N
Dizzy spells	Y	P	N	High fevers	Y	P	N

EYES

Glasses or contacts	Y	P	N	Tearing or dryness	Y	P	N
Eye pain/strain	Y	P	N				

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EARS

Earaches	Y	P	N	Impaired hearing	Y	P	N

NOSE AND SINUSES

Frequent colds	Y	P	N	Nose Bleeds	Y	P	N
Stuffiness	Y	P	N	Hayfever	Y	P	N
Sinus problems	Y	P	N	Loss of smell	Y	P	N

MOUTH AND THROAT

Frequent sore throat	Y	P	N	Canker sores	Y	P	N
Breath odor	Y	P	N				

RESPIRATORY

Cough	Y	P	N	Wheezing	Y	P	N
Asthma	Y	P	N	Bronchitis	Y	P	N

CARDIOVASCULAR

Heart disease	Y	P	N	Murmurs	Y	P	N

URINARY

Frequent urination	Y	P	N	Bed wetting	Y	P	N

GASTROINTESTINAL

Belching/passing gas	Y	P	N	Stomach aches	Y	P	N
Constipation	Y	P	N	Diarrhea	Y	P	N
Bowel Movements	How often _____						

MUSCULOSKELETAL

Joint pain/stiffness	Y	P	N	Muscle spasms/cramps	Y	P	N	Broken
bones	Y	P	N					

BLOOD/PERIPHERAL VASCULAR

Anemia	Y	P	N	Easy bleeding/bruising	Y	P	N

Is there any information about your child's health that you would like to add?

What expectations do you have for your child from working with our clinic?