



Pediatric Intake Form

Child's Name: _____ Birth date: _____ Age: _____

Address: _____ Contact Phone: _____

1st Parent's Name: _____ Age: ____ Occupation: _____

2nd Parent's Name: _____ Age: ____ Occupation: _____

Parent's Marital Status: Married/Partnered Separated Divorced Widowed Other

Siblings Names and Ages: _____

School and Grade: _____

Current Physician: _____

Please remember this is a confidential report. Your honest evaluation is both pertinent and necessary to better enable the doctor to accurately assess the health of your child and effectively work with you to improve your child's general well being.

I: Current Information:

Main health problem (when did it start, describe the course of symptoms, what treatment have you tried?):

Is your child currently taking any medication? ___ Yes ___ No

If so, what medicine and for what condition _____

Is there anything that you would like to discuss without your child present? Describe:

II: Pregnancy: Please circle any area that applied to the child's mother before/during her pregnancy:

- | | | |
|---|--|---|
| <input type="checkbox"/> Child adopted | <input type="checkbox"/> Regular prenatal care | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Fertility treatments/IVF | <input type="checkbox"/> Attitude-Happy (majority of time) | <input type="checkbox"/> Allergic reactions |
| <input type="checkbox"/> Recreational drug use | <input type="checkbox"/> Attitude-Depressed | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Complications in pregnancy | <input type="checkbox"/> Physical injury |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Any diagnosed illnesses | <input type="checkbox"/> Mental trauma |
| <input type="checkbox"/> Caffeine: soda, coffee, teas, chocolate, etc | <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Toxic exposure |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Forced bed-rest | <input type="checkbox"/> Premature contractions |
| <input type="checkbox"/> Daily vitamins/minerals | <input type="checkbox"/> Excessive decrease in weight | <input type="checkbox"/> Bleeding |
| <input type="checkbox"/> Immunization during pregnancy | <input type="checkbox"/> Excessive increase in weight | <input type="checkbox"/> Carried to full term |

Mother's age at child's conception: _____

Whooping cough Mumps Other: _____
 Does your child have any allergy problems (rash, itching, swelling, difficulty breathing, sneezing, etc)
 a) When eating food? Yes No What foods? _____
 How does the child react? _____
 b) When taking medication? Yes No What medicine? _____
 How does the child react? _____
 c) When near animals, furs, insects, dust, etc? Yes No What things? _____
 How does the child react? _____
 d) At certain times of year? Yes No When? _____
 How does the child react? _____

VII General: (Please check all that apply)

Poor appetite Cold hands Insomnia/sleep problems Weakness
 Excess appetite Cold feet Heavy sleeper Poor coordination
 Change in appetite Chills Wakes in a foul mood Vertigo/dizziness
 Food cravings Fever Irregular naps Fatigue
 Nail biting Sweats easily Night sweats Snores while sleeping
 Sudden energy drops-at what time? _____
 Bleed or bruise easily-where? _____
 What time does child usually go to sleep at night? _____ What time does child usually wake? _____
 Does child nap? Yes No When? _____

VIII Skin and Hair: (Please check all that apply)

Rashes Ulcerations Psoriasis Itching
 Eczema Pimples/Acne Hives Moles/warts
 Change in hair/skin texture Other hair or skin problems _____

IX Head, Eyes, Ears, Nose, and Mouth: (Please check all that apply)

Dizziness Spots in eyes Ringing in ears Grinding teeth
 Concussions Poor vision Poor hearing Cavities/fillings
 Facial pain Blurry vision Nose bleeds Braces
 Eye strain Dark circles under eyes Snotty/Runny nose Canker sores
 Color blindness Corrective lenses Nasal congestion Lip/Tongue Sores
 Night blindness Earaches Sinus problems Sore throats
 Eye pain Ear infections Teeth problems Ear tubes
 Headaches – where and when? _____

 Other head or neck problems? _____

X Respiratory: (Please check all that apply)

Cough Coughing blood Tight chest Wheezing/Asthma
 Difficulty in breathing when lying down Frequent or recurrent colds/flu
 Production of phlegm – color? _____ Other lung problems: _____

XI Gastrointestinal: (Please check all that apply)

Nausea Sensitive abdomen Bloody stools Rectal pain
 Vomiting Pain or cramps Black stools Hemorrhoids
 Belching Excess Gas Constipation Anal itching
 Bad breath Diarrhea Laxative use: _____/week; Type: _____

___ Other intestinal problems: _____
 Bowel Movements: Frequency: _____ Color: _____ Odor: _____ Texture/Form _____

XII Genito-Urinary: (Please check all that apply)

- ___ Pain on urination ___ Frequent urination ___ Blood in urine ___ Urgency to urinate
 ___ Unable to hold urine ___ Bedwetting
 ___ Wakes to urinate. How often? _____/night
 ___ Urinary tract infections ___ Vaginal infections
 ___ Discharge from vagina or penis ___ Early sexual development

___ Other urinary or genital problems: _____

XIII. Musculoskeletal: (Please check all that apply)

- ___ Neck pain ___ Back pain – Where? _____
 ___ Muscle cramps ___ Joint pains – Where? _____
 ___ Sprains/Strains ___ “Growing” pains ___ Shin splints ___ Excessively ticklish
 ___ Other joint or bone problems: _____

XIV. Neuro-psychological: (Please check all that apply)

- ___ Fidgety (hands and feet) ___ Impatient ___ Difficulty completing tasks
 ___ Easily stressed/anxious ___ Seizures ___ Trouble with reading/Concentrating
 ___ Bad temper ___ Social difficulties ___ Learning disabilities
 ___ Hyperactive ___ Nightmares/terrors ___ Sleepwalks

Predominant emotion/mood:

- ___ Angry ___ Sad ___ Worried ___ Happy ___ Shy ___ Fearful ___ Depressed

___ Treated for emotional problems – describe: _____

___ Other neurological or psychological problems: _____

XV: Family Medical History: If any blood relative to your child have or have had any of the following illnesses, please check accordingly: M (Mother), F (Father), S (Sibling), PGM (Paternal Grandmother), PGF (Paternal Grandfather), MGM (Maternal Grandmother), MGF (Maternal Grandfather)

M	F	S	PGM	PGF	MGM	MGF	
___	___	___	___	___	___	___	Allergy, asthma, or eczema
___	___	___	___	___	___	___	Auto-immune disease
___	___	___	___	___	___	___	Cancer
___	___	___	___	___	___	___	Diabetes or low blood sugar
___	___	___	___	___	___	___	Heart trouble
___	___	___	___	___	___	___	High blood pressure/Stroke
___	___	___	___	___	___	___	Kidney disease
___	___	___	___	___	___	___	Liver disease
___	___	___	___	___	___	___	Tuberculosis
___	___	___	___	___	___	___	Thyroid problems
___	___	___	___	___	___	___	Neurological conditions
___	___	___	___	___	___	___	Mental illness/Nervous disorder
___	___	___	___	___	___	___	Alcoholism/Addiction
___	___	___	___	___	___	___	Other: _____

XVI. Diet/Nutrition:

What are your child’s three favorite foods? _____

What are the three healthiest foods your child eats during an average week? _____

What are the three worst foods that your child eats during an average week? _____

Dietary habits (Please check all that apply):

D=Daily F=Frequently O=Occasionally R=Rarely N=Never

D	F	O	R	N	
___	___	___	___	___	Fresh Fruits
___	___	___	___	___	Fresh Vegetables
___	___	___	___	___	Raw Foods
___	___	___	___	___	Sprouted Foods
___	___	___	___	___	Whole Grains
___	___	___	___	___	Unrefined cereals
___	___	___	___	___	Legumes/Beans
___	___	___	___	___	Nuts/Seeds
___	___	___	___	___	Dairy Products
___	___	___	___	___	Peanut Butter
___	___	___	___	___	Honey/Molasses
___	___	___	___	___	Fruit Juices
___	___	___	___	___	Soy Products
___	___	___	___	___	Eggs
___	___	___	___	___	Fish
___	___	___	___	___	Fowl
___	___	___	___	___	Red meat
___	___	___	___	___	Hot dogs/Cold cuts
___	___	___	___	___	White Flour Products (Bread, bagels, crackers, pasta)
___	___	___	___	___	White Sugar Products
___	___	___	___	___	Artificial Sweeteners
___	___	___	___	___	Artificial Colors
___	___	___	___	___	Fried Foods
___	___	___	___	___	Fast Food
___	___	___	___	___	Pre-Packaged Foods
___	___	___	___	___	Soda Pop
___	___	___	___	___	Chocolate
___	___	___	___	___	Candy/Sweets/Desserts

List herb, vitamin & mineral supplements your child is currently taking
