

### Pediatric Intake Form

*Please complete the following questionnaire as thoroughly as possible to aid your physicians in their diagnosis and treatment. This will become part of your confidential medical record and will not be released unless you have authorized for us to do so. PLEASE PRINT CLEARLY.*

Child's Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Child's Age \_\_\_\_\_ Date of birth \_\_\_\_\_ (M/D/Y) Sex M / F  
Full Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone number: Home: \_\_\_\_\_  
Insurance Information: Company Name: \_\_\_\_\_ Policy Num.: \_\_\_\_\_

Who is filling out this form? \_\_\_\_\_  
With whom does the child live? \_\_\_\_\_  
May we leave messages relating to your child's visits? Yes / No

Emergency contact:  
Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Home phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

How did you hear about our Office: \_\_\_\_\_  
Referred by: \_\_\_\_\_

Other health care providers (i.e. Medical Doctor, Pediatrician, Chiropractor)  
the child is seeing:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list your child's health concerns in order of importance:  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_  
5. \_\_\_\_\_

#### Medical history

Was this child adopted? Y / N If yes, at what age? \_\_\_\_\_

Please complete as much of the following information as you know.

Child's Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Type: \_\_\_\_\_

Has your child ever experienced any of the following illnesses (Please Circle)?

- |                          |               |                  |                 |
|--------------------------|---------------|------------------|-----------------|
| Rubella                  | Mumps         | Measles          | Chickenpox      |
| Whooping                 | Cough Scarlet | Fever Polio      | Rheumatic fever |
| Diaper rash              | Cradle cap    | Diarrhea         | Constipation    |
| High Fevers              | Bedwetting    | Strep throat     | Frequent Colds  |
| Stomachaches             | Headaches     | Gastroesophageal | Reflux          |
| Heat or cold intolerance |               |                  |                 |

Ear infections: How many \_\_\_\_\_ per \_\_\_\_\_ (how often)?

Has your child received any of the following vaccinations (date it was received)?

- |        |       |            |       |
|--------|-------|------------|-------|
| DPT    | _____ | Flu        | _____ |
| MMR    | _____ | Smallpox   | _____ |
| HiB    | _____ | Pneumovax  | _____ |
| Polio  | _____ | Chickenpox | _____ |
| TB     | _____ |            |       |
| Other: | _____ |            |       |

Did your child have any adverse reactions or chronic illness following vaccination?

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Does your child get regular screening tests done by another doctor? Yes/No  
Has your child had any serious conditions, illnesses or injuries, or any hospitalizations? (Please list along with approximate dates.)

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Does your child have any known allergies (medicines, environmental, etc.)?

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Is your child **currently** taking any medications or supplements (prescription, over-the counter, vitamins, herbs, homeopathics, etc.)? Please list.

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**Prenatal Health and History**

Parental History	Blood Type	Health at conception (circle)	Health through pregnancy (circle)	Age at time of child's birth	# of previous pregnancies
Mother		Poor Fair Good Excellent Unknown	Poor Fair Good Excellent Unknown		
Father		Poor Fair Good Excellent Unknown	Poor Fair Good Excellent Unknown		N/A

Did the mother experience any food cravings/aversions during pregnancy? Y / N  
If yes, please list?

\_\_\_\_\_

\_\_\_\_\_

Did the mother receive medical care during pregnancy? Y / N / Unknown

Did the mother experience any of the following during pregnancy (Please circle)?

Bleeding      High blood pressure      Nausea      Physical/emotional trauma  
Vomiting      Thyroid problems      Diabetes      Other \_\_\_\_\_

Were any of the following interventions used during pregnancy?

Ultrasound      Amniocentesis      Chorionic villi sampling  
Triple Screen      Maternal serum screening  
Other: \_\_\_\_\_

Did mother use any of the following during pregnancy?

Tobacco      Alcohol  
Recreational drugs: \_\_\_\_\_  
Prescription medications: \_\_\_\_\_  
Over-the-counter medications: \_\_\_\_\_  
Vitamins and/or supplements: \_\_\_\_\_

**Birth History**

Term length: Pre-term (less than 37 wks): \_\_\_\_\_ wks  
Full-term (38-42 wks): \_\_\_\_\_ wks  
Post-term (more than 42 wks): \_\_\_\_\_ wks

Type of birth: Vaginal or C-section

Interventions:

Induction      Use of forceps      Epidural/anesthesia      Episiotomy  
Other: \_\_\_\_\_

Were there any complications during delivery? \_\_\_\_\_  
Length of labor: \_\_\_\_\_ hrs. Weight of infant at birth: \_\_\_\_\_ kg / lbs

APGAR score, if known (0 to 10):

1 minute \_\_\_\_\_ 5 minutes \_\_\_\_\_ 10 minutes \_\_\_\_\_

Did the child experience any of the following at or shortly after birth?

Jaundice \_\_\_\_\_ Rashes \_\_\_\_\_ Seizures \_\_\_\_\_

Birth injuries: \_\_\_\_\_

Infections: \_\_\_\_\_

Difficulties with feeding: \_\_\_\_\_

Birth defects: \_\_\_\_\_

**Health and Development**

At what age did your child first:

Sit up \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_ Talk \_\_\_\_\_

At what age did your child begin teething? \_\_\_\_\_

Were there any difficulties associated with teething? \_\_\_\_\_

If the child has started their menses, at what age did it begin? \_\_\_\_\_

Has your child experienced any pubertal changes? \_\_\_\_\_

**Nutritional History**

How was your infant fed? Breast fed Formula

How long? \_\_\_\_\_ Milk/Soy/Other: \_\_\_\_\_

Did your infant experience any reactions to the breast milk or formula?

\_\_\_\_\_

What foods were introduced **before 6 months**? Please list the approximate month. Any reactions?

\_\_\_\_\_

\_\_\_\_\_

What foods were introduced **between 6 and 12 months**? Were there any reactions to these foods?

\_\_\_\_\_

\_\_\_\_\_

Did your child ever experience colic? Y/N If yes, how severely?

Mild / Moderate / Severe

Does your child have any food allergies or intolerances? Please list.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child have any dietary restrictions (vegetarian/vegan, religious, etc.)?

\_\_\_\_\_

\_\_\_\_\_

Please describe your child's eating habits (e.g., good appetite, picky eater, etc.).

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Does the child have strong aversions to any foods?

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**Sleep Patterns**

What time does your child usually go to bed? \_\_\_\_\_

Wake in the morning? \_\_\_\_\_

Does your child nap during the day? Y / N What time(s): \_\_\_\_\_

Does your child have nightmares? Y / N How often? \_\_\_\_\_

Does your child have any problems associated with sleeping (e.g. trouble falling asleep, grinding teeth, sleep walking, etc.)? \_\_\_\_\_

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**Social Patterns**

Is your child in: school / daycare / homecare / other: \_\_\_\_\_

What grade level: \_\_\_\_\_

How would you describe your child's behavior at school?

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How about behavior at home? \_\_\_\_\_

Does your child make friends easily? \_\_\_\_\_

What are your child's interests & favorite activities? \_\_\_\_\_

According to your child, does he/she enjoy these activities? \_\_\_\_\_

Is your child physically active regularly? Y / N

How much & how often? \_\_\_\_\_

Does your child have any habits (i.e. thumb sucking)? \_\_\_\_\_

Does your child have any fears? \_\_\_\_\_

How much television does your child watch? \_\_\_\_\_ hours/day.

Does your child play on the computer or video games? Y / N

If yes, \_\_\_\_\_ hrs/wk

How often does your child read (not for school), or How often does someone read to your child? Daily Several times a week Weekly Less than weekly

**Environment**

Are there any pets in the home? Y / N What type and how many? \_\_\_\_\_

Does anyone in the child's household smoke? Y / N

How is the child's home heated \_\_\_\_\_

Are there humidifiers used in your home? \_\_\_\_\_

How would you describe the emotional climate of the child's home? \_\_\_\_\_

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Has your child ever had any significant physical or emotional traumas?

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Please write a little about your child's personality, both positive and negative? Is there anything you would want to change?

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THANK YOU for your time and patience in filling out this rather lengthy form!