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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 # (Cell): (_____)_____________

Parent's e-mail address: ____

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

Test	When	Where
Electroencephalogram (EEG)		
Psychological evaluation		
Hearing tests		
Speech/Language tests		

Hospitalizations/ Surgeries/ Injuries

What hospitalizations, surgeries or injuries has your child had?

____

____

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				

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?

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