

Pediatric Intake Form

Today's Date ____/____/____

Patient Name _____	DOB _____	Age _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address _____	City _____	State _____	Zip _____

Parent or Guardian Contact Information	
Name _____	Relationship to Child _____
<input type="checkbox"/> (check box if address is same as above)	
Address _____	City _____ State _____ Zip _____
Home Phone _____	Cell or Alternate Phone _____ E-mail _____
Parents are: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law <input type="checkbox"/> Other: _____	
How did you hear about us? _____	

Emergency Contact	
Name _____	Relationship to Child _____
Phone _____	Cell or Alternate Phone _____

Pediatrician	
Name _____	Phone _____
Address _____	City _____ State _____ Zip _____

Health Concerns	
Please list health concerns in order from most bothersome to least bothersome. Please include Mental, Emotional, and Physical concerns.	
1) _____	Length of Time _____
2) _____	Length of Time _____
3) _____	Length of Time _____
4) _____	Length of Time _____

Birth History																	
<p style="text-align: center;">Prenatal</p> <p>Previous Preg.(#)_____ Previous Births(#)_____</p> <p>At time of conception: Mother's Age _____ Father's Age _____</p> <p>Mother's Pregnancy History: Please check all that apply.</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Nausea/vomiting</td> <td><input type="checkbox"/> High Blood Pressure</td> </tr> <tr> <td><input type="checkbox"/> Anemia</td> <td><input type="checkbox"/> Preeclampsia</td> </tr> <tr> <td><input type="checkbox"/> Gestational Diabetes</td> <td><input type="checkbox"/> Thyroid Condition</td> </tr> <tr> <td><input type="checkbox"/> Bleeding</td> <td><input type="checkbox"/> Physical Trauma</td> </tr> <tr> <td><input type="checkbox"/> Infection</td> <td><input type="checkbox"/> Emotional Stress</td> </tr> <tr> <td><input type="checkbox"/> Coffee</td> <td><input type="checkbox"/> Smoking</td> </tr> <tr> <td><input type="checkbox"/> Recreational Drugs</td> <td><input type="checkbox"/> Alcohol</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Prescription Medication (please list)</td> </tr> </table> <p>_____</p> <p>_____</p> <p>Did you take a prenatal vitamin: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Anemia	<input type="checkbox"/> Preeclampsia	<input type="checkbox"/> Gestational Diabetes	<input type="checkbox"/> Thyroid Condition	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Physical Trauma	<input type="checkbox"/> Infection	<input type="checkbox"/> Emotional Stress	<input type="checkbox"/> Coffee	<input type="checkbox"/> Smoking	<input type="checkbox"/> Recreational Drugs	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Prescription Medication (please list)		<p style="text-align: center;">Birth</p> <p>Did baby deliver on time? _____ (If No, + weeks = _____, or - weeks = _____).</p> <p>Length of Labor _____</p> <p>Vaginal Birth or C-Section _____</p> <p>Babies birthweight (lbs) _____ Length (in.) _____</p> <p>Were there any birth complications? _____ _____ _____</p>
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Hospitalizations, Surgeries, and Major Illnesses	Vaccination History										
<table style="width: 100%; border: none;"> <tr> <td style="width: 60%;">Condition or Procedure</td> <td style="width: 40%;">Date</td> </tr> <tr> <td>1) _____</td> <td>_____</td> </tr> <tr> <td>2) _____</td> <td>_____</td> </tr> <tr> <td>3) _____</td> <td>_____</td> </tr> <tr> <td>4) _____</td> <td>_____</td> </tr> </table>	Condition or Procedure	Date	1) _____	_____	2) _____	_____	3) _____	_____	4) _____	_____	<p>Please check all that apply.</p> <p><input type="checkbox"/> HepB <input type="checkbox"/> DTP <input type="checkbox"/> Hib <input type="checkbox"/> Polio <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> Other _____</p> <p>Any reactions or complications from vaccinations? _____ _____</p>
Condition or Procedure	Date										
1) _____	_____										
2) _____	_____										
3) _____	_____										
4) _____	_____										

Medications	Supplements																				
<p>Please list all prescription and over-the-counter medications child is currently taking.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 60%;">Medication</td> <td style="width: 40%;">Dosage</td> </tr> <tr> <td>1) _____</td> <td>_____</td> </tr> <tr> <td>2) _____</td> <td>_____</td> </tr> <tr> <td>3) _____</td> <td>_____</td> </tr> <tr> <td>4) _____</td> <td>_____</td> </tr> </table>	Medication	Dosage	1) _____	_____	2) _____	_____	3) _____	_____	4) _____	_____	<p>Please list all supplements child is currently taking, including brand names.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 60%;">Supplement</td> <td style="width: 40%;">Dosage</td> </tr> <tr> <td>1) _____</td> <td>_____</td> </tr> <tr> <td>2) _____</td> <td>_____</td> </tr> <tr> <td>3) _____</td> <td>_____</td> </tr> <tr> <td>4) _____</td> <td>_____</td> </tr> </table>	Supplement	Dosage	1) _____	_____	2) _____	_____	3) _____	_____	4) _____	_____
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4) _____	_____																				

Health History
<p>Any known allergies to foods, medications, environmental or other allergy? Please describe.</p> <p>_____</p> <p>_____</p> <p>_____</p>

