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## Pediatric Intake

Today's date: \_\_\_\_\_

Child's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Gender: M F

Who is filling out this form (name and relation)?: \_\_\_\_\_

### Contacts (in order of preference):

Name \_\_\_\_\_ Phone \_\_\_\_\_ h

Address \_\_\_\_\_ w

\_\_\_\_\_ other

Relationship to child \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ h

Address \_\_\_\_\_ w

\_\_\_\_\_ other

Relationship to child \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ h

Address \_\_\_\_\_ w

\_\_\_\_\_ other

Relationship to child \_\_\_\_\_

Whom does the child live with? \_\_\_\_\_

### Other health care providers:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

### What are your child's health concerns, in order of importance:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

**Medical history**

How would you describe your child’s general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Which of the following has your child had? (n – never, m – mild, a – average, s – severe)

- |                                  |                        |                        |
|----------------------------------|------------------------|------------------------|
| n m a s rubella (German measles) | n m a s roseola        | n m a s impetigo       |
| n m a s measles                  | n m a s scarlet fever  | n m a s mononucleosis  |
| n m a s chicken pox              | n m a s whooping cough | n m a s ear infections |
| n m a s mumps                    | n m a s strep throat   |                        |

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

\_\_\_\_\_  
\_\_\_\_\_

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How many times has your child been treated with antibiotics? \_\_\_\_\_

Please indicate which immunizations your child has received:

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus) | <input type="checkbox"/> Haemophilus influenza B | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Tetanus booster; when? _____         | <input type="checkbox"/> “Flu”                   | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> MMR (measles, mumps, rubella)        | <input type="checkbox"/> Polio                   |                                      |

Other: \_\_\_\_\_

Please indicate any adverse reaction your child experienced in response to a vaccination:

\_\_\_\_\_  
\_\_\_\_\_

What screening tests has your child had (blood, hearing, vision, etc.) \_\_\_\_\_

\_\_\_\_\_

**Prenatal health**

How would you describe the health of the parents at conception?

Mother      Poor   Fair   Good   Excellent   Unknown

Father      Poor   Fair   Good   Excellent   Unknown

How would you describe the health of the mother during the pregnancy?

Poor   Fair   Good   Excellent   Unknown

What was the mother's age at child's birth? \_\_\_\_\_

Did the mother receive prenatal medical care?   Y   N   Unknown

Did the mother experience any of the following during the pregnancy:

- Bleeding       High blood pressure       Diabetes       Thyroid problems
- Physical or emotional trauma

Other: \_\_\_\_\_  
 \_\_\_\_\_

Did the mother use any of the following during the pregnancy?

- Tobacco    Alcohol    Recreational drugs: \_\_\_\_\_
- Prescription medications: \_\_\_\_\_
- Over-the-counter medications: \_\_\_\_\_
- Supplements: \_\_\_\_\_
- Other: \_\_\_\_\_

Was the mother exposed to significant second-hand smoke during pregnancy?:   Y   N

**Birth history**

Term length:  Full       Premature: \_\_\_\_\_ wks       Late: \_\_\_\_\_ wks

Length of labour: \_\_\_\_\_      Weight at birth \_\_\_\_\_

Any complications? \_\_\_\_\_

Was the birth:   Vaginal/C-section   Induced   Forceps   Anesthesia used

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

- Jaundice    Rashes    Seizures    Birth injuries \_\_\_\_\_
- Birth defects \_\_\_\_\_
- Other \_\_\_\_\_

**Family history**

Indicate whether a close relative (parent, sibling) has had any of the following

	Who?		Who?
Allergies		Diabetes	
Asthma		Kidney disease	
Birth defects		Other	
Juvenile arthritis			

I don't know the family medical history of the child

Do either of the parents have a chronic illness?   Y   N   Please describe:

\_\_\_\_\_

**Diet**

How was your infant fed?

Breast fed. How long?: \_\_\_\_\_  Formula. Milk/Soy/Other: \_\_\_\_\_

Other: \_\_\_\_\_

What foods were introduced before 6 months? (Please list approximate month as well):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6–12 months?:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did your child ever experience colic?: Y N How severe? mild moderate severe

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

Describe a typical day's diet:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Beverages (type and amount) \_\_\_\_\_

**Environment**

Is the child in school daycare home care other : \_\_\_\_\_

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

\_\_\_\_\_

Does the child exercise regularly? Y N Please describe the type and frequency of physical activity:

\_\_\_\_\_

\_\_\_\_\_

How much television does your child watch? \_\_\_\_\_ hrs a day/week

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

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

Are there animals in the home? Y N

Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)? Please describe:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

How would you describe your child's temperament?

\_\_\_\_\_

How would you describe your child's behavior in school/ daycare?:

\_\_\_\_\_

Is there anything that you feel is important that has not been covered?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_