Health Matters
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Pediatric Intake Form

Name: ____

Gender: ☐ M ☐ F Age:____________ Date of Birth: ____________________

Parent's Names: ____

Address:____

Who does the child live with? ____

Phone: ( )____

Emergency Contact: ____________________ Phone: ( ) ____________________

Email: ____

Any life threatening allergies? ____

What would you like to be addressed at this visit? ____

____

When did this begin? ____

What treatments have been attempted?____

What was the result with these treatments? ____

Preferred pharmacy?____

Has your child had any of the following? *Check all applicable*

☐ Chicken pox ☐ Measles ☐ Mumps ☐ Rubella ☐ Surgery ☐ Allergies

Vaccinations: *Check all applicable*

☐ DTaP (Diphtheria, Pertussis, Tetanus) ☐ Hib (H. influenza) ☐ MMR (Measles, Mumps, Rubella)
☐ Rotavirus ☐ OPV (oral polio vaccine) ☐ Hepatitis B
☐ Flu shot ☐ Pneumococcal (PCV13) ☐ HPV
☐ No vaccinations at this time ☐ Varicella (Chicken Pox)

Has your child ever been to the emergency room?

When?____

Why? ____

What medications is your child currently taking?____

What medications has your child previously taken? ____

What vitamins, minerals, herbal medication or homeopathic supplements is your child currently taking? ________

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Was your child exposed to any of the following during the pregnancy?

☐ Alcohol ☐ Cigarette smoke ☐ Recreational drugs ☐ Prescription medications

☐ Over the Counter drugs ☐ Herbal preparations ☐ Ultrasound ☐ Amniocentesis

☐ Illness ☐ Large amount of stress

Were there any complications during the pregnancy?

☐ Nausea ☐ Hypertension ☐ Vomiting ☐ Preeclampsia / eclampsia

☐ Bleeding ☐ Placenta previa ☐ Gestational diabetes ☐ Maternal rubella

☐ Maternal chicken pox ☐ Maternal cytomegalovirus ☐ Maternal toxoplasmosis ☐ Other

At Birth: Weight: ________________ Length:________________

Was your child? ☐ Full term ☐ Pre-term ☐ Post-term ☐ Premature

Where did the birth take place? ☐ Home ☐ Hospital ☐ Birth Center, name ________________________

What type of delivery occurred? ☐ Vaginal ☐ Cesarean Section

Were there any complications with the birth? ☐ Difficult delivery ☐ Breech delivery

☐ Long 2nd stage of labor ☐ Shoulder dystocia Forceps or suction used ☐ Other

What were the APGAR scores (if known)? ____

Were any interventions administered at birth? ☐ Vitamin K ☐ Eye drops ☐ Hepatitis B vaccine

What were the mother's feelings about the birth? ____

As a newborn, did your child have any of the following conditions?

☐ Jaundice ☐ Colic ☐ Failed hearing screen

☐ Hip displacement ☐ Meningitis ☐ Scoliosis

What does your child like to eat?

As a baby was he/she breastfed? ☐ Yes ☐ No For how long? ________________________________

Fed formula? ☐ Yes ☐ No What kind of formula was used? ________________________

Were there any reactions to the formulas? ____

When were solid foods introduced? ____

What were those foods? ____

Were there any reactions to any foods? ____

What does your child eat now? ____

What are his/her favorite foods? ____

What foods does your child like the least? ____

Where do you live? ____

What kind of a building do you live in (house, apartment, etc.)? _____________________________

How old is the building? ____

Has it been renovated recently?____

Does your home have carpet? ____

Has there ever been a problem with mildew in the home? __________________________________

Any pertinant family medical history, such as:

☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Hypothyroidism ☐ Arrhythmia

☐ Rheumatoid ☐ Arthritis ☐ High blood pressure ☐ Lupus ☐ Sickle-cell anemia ☐ Crohn's Disease

☐ An Autoimmune disease ☐ Irritable Bowel Syndrome ☐ Ulcerative Colitis

Who was affected? ____________________

Where does your child go to school/daycare? ____________________

Does your child have in-home childcare? ☐ Yes ☐ No

Does your child play well with other kids? ☐ Yes ☐ No

Do you have pets at home? ☐ Yes ☐ No What kind? ____________________

Watch TV? ☐ Yes ☐ No How often/hours? ____________________

Play video games? ☐ Yes ☐ No How often/hours? ____________________

Play on the internet? ☐ Yes ☐ No How often/hours? ____________________

Family time? ☐ Yes ☐ No How often/hours? ____________________

Exercise? ☐ Yes ☐ No How often/hours? ____________________

What does your child like to do for exercise? ____________________

What else does your child like to do? ____________________

What position does he/she like to sleep in? ____________________

How long does he/she sleep at night? ____________________

Does he/she wake up during the night? ____________________

Does he/she have nightmares? ☐ Yes ☐ No _____ How often? ____________________

How does your child feel when he/she wakes up? ____________________

Does your child take naps? ☐ Yes ☐ No How often? ____________________

How is his/her energy during the day? ____________________

Please check all that apply to your child's medical history:

☐ Cradle cap (seborrheic dermatitis) ☐ ADHD/ ADD ☐ Eczema ☐ Urinary incontinence

☐ Diaper rash ☐ Bedwetting ☐ Yeast infection ☐ Fecal incontinence

☐ Impetigo ☐ Seizures ☐ Conjunctivitis ☐ Paralysis

☐ Scabies ☐ Cerebral Palsy ☐ Sinusitis ☐ Spina bifida

☐ Ear infections ☐ Cystic Fibrosis ☐ Chronic colds ☐ Chronic diarrhea

☐ Croup Appendicitis ☐ Bronchitis ☐ Constipation ☐ Asthma

☐ Chronic abdominal pain ☐ Pneumonia ☐ Short stature ☐ Cardiovascular problems

☐ Other

Please include any other important information not listed above: ____________________

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