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PEDIATRIC INTAKE Today's Date ________________

HISTORY

Child/Patient's name _______________________________ Age _____ Sex _____ Birth date _______________

Address ____

Mother's name _______________________ Father's name _________________ Other __________________

Phone (home) ________________________ (work) ________________________ mother / father / other

Health Insurance Co. _______________________________ Referred by _______________________________

Person to be notified in case of emergency: Name __________________________ Relationship _____________

Address ____ Phone __________________

Please list symptoms of concern & most important health problems:

1.) ____
2.) ____
3.) ____
4.) ____
5.) ____

Medications	Now	Past	Frequency	Supplements	Now	Past	Frequency
Aspirin	______	______	____________	Vitamins	______	______	____________
Tylenol	______	______	____________	Minerals	______	______	____________
Antibiotics	______	______	____________	Fluoride	______	______	____________
Decongestants	______	______	____________	Herbs	______	______	____________

Other ____

Allergies to Drugs or Medications ____

____

Childhood Illnesses:

______ Chicken Pox	______ Scarlet Fever	______ Mononucleosis
______ Measles	______ Rheumatic Fever	______ Ear infections
______ Mumps	______ Strep throat	______ Tonsillitis
______ Rubella	______ Pneumonia	______ Other _____________

Immunizations: (list types, approximate date given, and adverse reactions)

DPT Measles, Mumps, Rubella Polio Other Tuberculosis test

Hospitalizations/surgeries/accidents/serious injuries & illnesses: (describe each incident & give dates)
____
____
____
____
____
____

Family history: identify all family members who have or have had any of the following.

Alcoholism ____________	Epilepsy ____________	Other ____________
Allergies ____________	Heart disease____________	____________
Anemia ____________	Hearing loss ____________	Other ____________
Arthritis ____________	High blood pressure ____________	____________
Asthma ____________	Hypoglycemia ____________	Other ____________
Birth defects ____________	Mental illness ____________	____________
Cancer ____________	Obesity ____________	
Diabetes ____________	Stroke ____________	
Eczema ____________	Thyroid disorder ____________	

Does infant/child/adolescent have any of the above? yes no
If yes, which ones? ____

INFANT'S / CHILD'S / ADOLESCENT'S HEALTH HISTORY

	Now	Past	Never		Now	Past	Never
Acne	____	____	____	Epilepsy/seizures	____	____	____
Allergies	____	____	____	Fatigue	____	____	____
Anemia	____	____	____	Frequent infections	____	____	____
Asthma	____	____	____	Headaches	____	____	____
Bed wetting	____	____	____	Heart murmur	____	____	____
Birth defects	____	____	____	High fever	____	____	____
Colic	____	____	____	Hyperactivity	____	____	____
Constipation	____	____	____	Insomnia	____	____	____
Cough/wheeze	____	____	____	Jaundice	____	____	____
Cradle cap	____	____	____	Learning disorder	____	____	____
Depression	____	____	____	Moodiness	____	____	____
Diarrhea	____	____	____	Stuffy nose	____	____	____
Dizzy spells	____	____	____	Thrush	____	____	____
Earaches	____	____	____	Vomiting spells	____	____	____
Eczema	____	____	____	Other ________	____	____	____

What is your infant's/child's/adolescent's disposition?
____
____
____
____
____
____

PRENATAL / BIRTH / FEEDING HISTORY

1.) Previous pregnancies by natural mother and any complications:
____
____

2.) Mother's health during pregnancy: (check all that apply)

___ Age ___ Trauma/injury ___ Alcohol consumption
___ Bleeding ___ Stress ___ Drugs
___ Nausea ___ High blood pressure ___ Smoking
___ Illness ___ X-rays ___ Other ______________________
___ Toxemia ___ Medications ________________________________

3.) Term: Full ______ Premature _______________ Late ______________ Birth weight ___________________
4.) Was pregnancy easy? ____________________________ Difficult? __________________________________
5.) Place of Birth: Hospital ________ Home _______ Clinic ______ Other ______________________________
6.) Feeding: Breast fed ___________ How long? ________ Cow's milk _______________________________
Formula fed _________ How long? ________ Type of formula ____________________________
Age solid foods began _______ What foods? ____
Food allergy/intolerance ____
7.) Sample daily diet: (choose a typical day and include food and liquids)
____
____
____
____

SOCIAL HISTORY

1.) Parents: Married _____ Separated _____ Divorced ______ Widowed _____
Mother's occupation _____________________________________ Full time _________ Part time _________
Father's occupation ______________________________________ Full time _________ Part time _________

2.) Other guardian _____________________________________ Relationship _____________________________

3.) Others residing in home _____________________________ Relationship _____________________________

4.) Daycare/pre-school/school ____________________________ Where ___________________________________
How many hours each day ______________________________ Days of the week _________________________

5.) Siblings:

Name	Age	Health Problems
1)		
2)		
3)		
4)		
5)		

6.) Interaction with relatives: Who? __________________________ How often? ___________________________
Who? _____________________________ How often? ____
Who? _____________________________ How often? ____
Who? _____________________________ How often? ____