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Pediatric Intake Form

(A minor is anyone under the Age of 18)

Last Name of Child: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ Sex: _____ Address: _____

Today's Date: _____

Phone Number: _____ Legal Guardian's Name: _____

Present Mental Health/Behavioral Concerns

Please list your child's health concerns in order of priority, including date of onset and severity of symptoms.

1. _____
2. _____
3. _____
4. _____
5. _____

What do you believe is causing your child's most important behavioral or mental health concerns?

What goals do you have for your child's visit today?

Please list any alternative medicine providers (chiropractors, naturopaths, herbalists, etc) and specialists involved in your child's care:

Please list all medications, herbs, supplements, and homeopathic remedies used regularly by your child:

Please list and describe any allergies your child has to medications, supplements, or foods:

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Past Medical History: Please list the date of or age at each event and describe:

Serious Illnesses and Injuries: _____

Surgeries: _____

Hospitalizations: _____

Date of last physical: _____ Date of last blood tests: _____

Childhood Illnesses: Your child's health is: Good Fair Poor

Pregnancy History: Birth Mother: # of pregnancies: _____ # of children: _____ Age at delivery: _____

Please check any factors during pregnancy. Health during pregnancy: Good Fair

Poor

Alcohol Consumption

Nausea

Toxemia

Bleeding

Recreational Drugs

Trauma/Injury

High Blood Pressure

Smoking

X-rays

Stress

Medications: _____

Other health problems or complications during pregnancy: _____

Birth History:

Full Term Early _____ weeks Late _____ weeks Length of labor: _____ hours

Place of Birth: Hospital Birth Center Home

Other: _____

Birth Medications (if any): _____

Complications: _____

Newborn: Weight at birth: _____ lbs _____ oz Home from hospital in _____ days

Jaundice

Infection

Seizures

Cyanosis

Fever

Anemia

Other important conditions: _____

Feeding: Breast Fed _____ months Formula Fed _____ months Type of formula _____

Developmental Milestones: Please indicate your child's age at each milestone:

Sit up _____ months

Walk _____ months

First Word _____ months

Crawl _____ months

First Tooth _____ months

First Sentence _____ months

Toilet Trained _____ months

Additional comments about social, cognitive, or physical development: _____

Family History:

Have any of the child's parents, siblings, or grandparents ever had any of the following: (please circle)

Diabetes

Alcoholism/drug abuse

Depression/bipolar

Cancer type _____

Heart attacks/heart disease

High cholesterol

Thyroid problems

High blood pressure

Rheumatoid arthritis/lupus

Stroke

Osteoporosis

Other _____

Social History

Parents: Biological

Adoptive

Foster

Step-parent(s)

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Name of mom _____ Name of dad _____

Parents' Marital status: Single Married Divorced Re-married Widowed

Significant Other _____

Mother's Occupation: _____ Full or Part Time Father's Occupation: _____ Full or Part Time

Siblings: Yes No Please list their names and age(s) _____

Pre-School/Daycare/School: _____ Hours per day: _____ Days per week: _____

Do you have any academic concerns regarding your child? _____

Personality and Habits:

How does your child react to stressful events? _____

What are your child's primary sources of stress? _____

How much does stress impact your child's life? _____ Hours of play per day? _____

Favorite activities? _____

Does your child:

Exercise regularly? Yes No What kind? _____

Sleep soundly and wake rested? Yes No If no, why? _____

Sleep: _____ hours per night

Naps: _____ hours per day

Play well with others? Yes No If no, why? _____

Enjoy time alone? Yes No If no, why? _____

Have sensory sensitivities? Yes No What kind? _____

Have strong fears or phobias? Yes No What kind? _____

Have rituals/repetitive behaviors? Yes No What kind? _____

Diet:

Does your child have any dietary restrictions? _____

Your child's favorite foods? _____

Foods your child refuses? _____

How is your child's appetite? _____ Thirst? _____