



PEDIATRIC INTAKE (Birth to 13 years)

NAME: _____ **DOB:** _____

Parent/Caregiver's name: _____

Circle Relationship: (Mother / Father / Other)

Parent/Caregiver's name: _____

Circle Relationship: (Mother / Father / Other)

The patient lives with: (Mother / Father / Other) _____

Siblings (names and ages): _____

Has any other family member already been a patient at this clinic? _____

How did you hear about Northshore Family Practice?

What made you decide to come to this clinic? What do you know about our approach?

What *three* expectations do you have from *this* visit to our clinic?

- 1.
- 2.
- 3.

What *long-term* expectations do you have from working with our clinic?



HEALTHCARE STATUS

Name of clinic/hospital(s) where your child's health records are kept: _____

Name of Child Pediatrician/Primary Care Provider _____

Are you transitioning your child's primary care to our clinic (this would mean that we are now responsible for well child exams, immunizations, screenings, etc.)? Y / N

What are your child's most important health problems? List them in order of importance.

Please place a star () by any health issues you prefer NOT be discussed in front of your child. We may ask your child to step out, or this may require separate visits - one for evaluation and one to discuss treatment options.*

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Does your child have any contagious diseases at this time? No Yes: _____

PRENATAL HISTORY

Previous pregnancies for biological mother? No Yes: How many? _____

Miscarriages? No Yes: How many? _____

Complications? No Yes: _____

Mother's age at child's birth: _____

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Nausea | <input type="checkbox"/> Illnesses unrelated to pregnancy |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Diabetes – gestational or preexisting |
| <input type="checkbox"/> Tobacco, alcohol, or drug use | <input type="checkbox"/> Medications unrelated to pregnancy | |
| <input type="checkbox"/> Physical or emotional trauma | <input type="checkbox"/> Other: _____ | |

BIRTH HISTORY

The child was born: Term Premature: _____ Post-term/late:

Complications: No Yes: _____

Birth location (city & state/country): _____ Weight: _____

Breast fed: No Yes - How long: _____ Formula: No Yes – Type: _____

Age started solid foods: _____

HEALTH HISTORY

Previous Illnesses

Please list any illnesses/diseases your child has or has had and when. Ex. – serious infectious illnesses, traumas, congenital anomalies, hereditary diseases, etc.

Illness/Disease _____ Year: _____ Illness/Disease _____ Year: _____

Illness/Disease _____ Year: _____ Illness/Disease _____ Year: _____

Illness/Disease _____ Year: _____ Illness/Disease _____ Year: _____

Hospitalizations, Surgery and Imaging

Has your child had any hospitalizations, surgeries, x-rays, CAT scans, EEGs, EKGs or other procedures:

Procedure: _____ Year: _____ Procedure: _____ Year: _____

Procedure: _____ Year: _____ Procedure: _____ Year: _____

Procedure: _____ Year: _____ Procedure: _____ Year: _____

Immunizations – *check those that your child has received, in full or in part* Check here for all/up to date

- | | | | | |
|---------------------------------------|--|------------------------------------|-------------------------------|------------------------------------|
| <input type="checkbox"/> Polio | <input type="checkbox"/> DTP | <input type="checkbox"/> MMR | <input type="checkbox"/> HepB | <input type="checkbox"/> Varicella |
| <input type="checkbox"/> Hib | <input type="checkbox"/> Rotovirus | <input type="checkbox"/> Influenza | <input type="checkbox"/> HepA | <input type="checkbox"/> HPV |
| <input type="checkbox"/> Pneumococcal | <input type="checkbox"/> Meningococcal | Others _____ | | |



Any adverse immunization reactions? No Yes – What was the reaction and with which immunization did it occur?

Allergies

Known allergies or sensitivities – *please list all known allergens/irritants*

Drugs: No Yes: _____

Foods: No Yes: _____

Envirommentals/chemicals: No Yes: _____

Current Medications

Please list any prescription medications, over the counter medications, vitamins or other supplements your child is taking, including the dosage:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

FAMILY HISTORY

Does anyone in your biological family have a history of any of the following? (*please check and write who*)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Anemia | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Hives | <input type="checkbox"/> Depression or Suicide |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Genetic Disorder | <input type="checkbox"/> Dementia | <input type="checkbox"/> Alcoholism / Addiction |
| <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Migraines | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Other: _____ |

Other relevant family history? _____

What is your child's heritage? _____



Is there any information about your child's health that you would like to add?

Welcome to Northshore Family Practice!
We are excited to start walking with you on your path to wellness.

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