



PEDIATRIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____
 Address _____
 City _____ State _____
 Home Phone _____
 Cell Phone _____
 Email _____
 Sex M F Age _____ Birthday _____

Mother's Name _____
 Mother's Occupation _____
 Mother's Phone _____
 Mother's Email _____

Father's Name _____
 Father's Occupation _____
 Father's Phone _____
 Father's Email _____

IN CASE OF EMERGENCY, CONTACT

Name _____
 Relationship _____
 Contact Number _____

Who may we thank for referring you? _____

HOW CAN WE HELP YOUR CHILD?

Wellness Checkup Other: _____

If your child is already experiencing a symptom, please describe it:

Has your child been treated on an emergency basis? Yes No

Please describe: _____

PREGNANCY HISTORY

Did you experience any complications during your pregnancy? (check all that apply)

Back/Other Pain Gestational Diabetes Pre/Eclampsia Strep B Nausea/Vomiting
 Pre-Term Fatigue Swelling Other (please describe) _____

BIRTH HISTORY

Type of birth (check all that apply):

Hospital Birth Center Home Normal / Vaginal Breech
 Cesarean Scheduled/Induced Epidural

Problems during labor / delivery? _____

Antibiotics Congenital Anomalies Failure to Thrive Jaundice Meconium
 Respiratory Distress Extended Hospitalization Other _____

Authorization for Care of Minor

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Signed: _____ Witnessed: _____ Date: _____



GROWTH & DEVELOPMENT

Infant feeding: Breast Bottle Formula

Number of hours of sleep each night: _____ Quality of sleep: _____

At what age did the child: _____

Respond to sound: _____ Crawl: _____ Hold head up: _____

Stand: _____ Sit unsupported: _____ Walk unsupported: _____

CHILDHOOD DISEASES, ILLNESSES & VACCINATION

Has your child had (check all that apply)?:

- | | | |
|--------------------------------------|----------------------------------|---|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles | <input type="checkbox"/> Rubeola |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Rubella | <input type="checkbox"/> Pertussis/Whooping Cough |

Has your child ever suffered from (check all that apply)?:

- | | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Digestive Issues
(constipation/diarrhea) | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Orthopedic Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic Ear Aches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Juvenile
Rheumatoid Arthritis | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Fainting | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Poor Appetite |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Colic | <input type="checkbox"/> Headaches | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Ruptures/Hernias |
| <input type="checkbox"/> Back Aches | <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Delayed Speech | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Diabetes | | | <input type="checkbox"/> Walking Problems |

Have you vaccinated your child?

- No Yes As scheduled Delayed Schedule

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list)

MEDICATIONS (list)

SURGERIES (list)

FAMILY HISTORY (list)

SIBLINGS

How many children do you have? _____

Number of pregnancies: _____

Children's' Ages: _____

Are you currently pregnant? No Yes, I'm due: _____

Childrens' health concerns: _____

Health concerns regarding this pregnancy? _____

Consent to perform and interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays.

The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

Signed: _____