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PEDIATRIC & ADOLESCENT INTAKE FORM

Today's Date:______________

Patient's Name ________________________ Age ____Date of Birth_______Gender____
SSN# ____
Address____
Mother's Name ___________________________ Father's Name ____________________
Phone (Home) ____________________________ (Work) ___________________________
Referred by ____________________________
Person to be Notified In Case of Emergency:
Name:___________________Relationship:______________Phone #:_________________

PLEASE LIST MOST IMPORTANT HEALTH CONCERNS / PROBLEMS

____
____
____
____

MEDICATIONS:

	Now	Past
Aspirin	____	____
Tylenol	____	____
Antibiotics	____	____
Decongestants	____	____
Other	____	____

SUPPLEMENTS:

	Now	Past
Vitamins	____	____
Minerals	____	____
Herbs	____	____

ALLERGIES TO DRUGS/MEDICATIONS:

____

CHILDHOOD ILLNESSES

Check all that apply:

___Chicken Pox
___Measles
___Mumps
___Rubella
___Whooping Cough
____Scarlet Fever
____Rheumatic Fever
____Strep Throat
____Pneumonia
___Asthma
____Mononucleosis
____Ear Infections
____Tonsillitis
____Croup
___ Other

PRENATAL / BIRTH / FEEDING HISTORY:

MOTHER'S HEALTH DURING PREGNANCY WITH THIS INFANT / CHILD / ADOLESCENT

Check and describe in space provided：

___Age	____Trauma/Injury	____Alcohol Consumption
___Bleeding	____Stress	___ Drugs
___Nausea	____High Blood Pressure	____Smoking
___Illness	____X-Rays	____Other
___Toxemia	____Medications	

Describe:

____

TERM:

___Full ____Premature ____Late ___ Birth Weight

Was Pregnancy / Birth: ____Easy ___Difficult

Place of Birth： ____Hospital ___Home ___Clinic ___Other________

FEEDING:

___Breast Fed ____How Long?

___Formula (Kind) ____How Long?

Age solid foods began ____ **What Foods** ____________________

Food Intolerances? ____

Favorite foods ____

DIET EATEN YESTERDAY

____

SOCIAL HISTORY:

Parents: ___Married ____Separated ___Divorced

Mother's Occupation ____________________ ____Full Time ____Part Time

Father's Occupation ____________________ ____Full Time ____Part Time

Guardian: _______________________ Relationship: ___________________

Others Residing in the Home: _________________ Relationship: ___________________

DAYCARE _________________________ Where: _______________________

	SIBLINGS NAME	AGE	HEALTH PROBLEMS
1			
2			
3			
4			

IMMUNIZATIONS:

(List types, dates given, and **any adverse reactions** *(ie fever, rash, colic, irritability,etc)*

DPT DT Hepatitis Tetanus(only) HIB Polio MMR Chicken Pox

Other:____

____

HOSPITALIZATIONS / SURGERIES /ACCIDENTS / SERIOUS INJURIES

Describe each incident and give date

____

____

FAMILY HISTORY:

(Identify all family members who have or have had any of the following)

___Alcoholism	____Cancer	____High Blood Pressure
___Allergies	___ Diabetes	___ Hypoglycemia
___Anemia	___ Eczema	____Mental Illness
___Arthritis	___Epilepsy	____Obesity
___Asthma	___Heart Disease	____Stroke
___Birth Defects	____Hearing Loss	____Thyroid Disorder

___Other (Describe) ____

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

(Check all that apply)

NOW	PAST		NOW	PAST		NOW	PAST	
___	___	Acne	___	___	Depression	____	____	High Fever
___	___	Allergies	___	___	Diarrhea	___	___	Hyperactivity
___	___	Anemia	____	____	Dizzy Spells	____	____	Insomnia
___	___	Asthma	___	___	Ear Aches	____	____	Jaundice
___	___	Bed Wetting	____	____	Eczema	____	____	Learning Dis
___	___	Birth Defects	____	____	Epilepsy/Seizure	____	____	Moodiness
___	___	Colic	____	____	Fatigue	____	____	Stuffy Nose
___	___	Constipation	____	____	Frequent Infections	____	____	Thrush
___	___	Cough/Wheeze	_____	____	Headaches	____	____	Vomiting Spell
___	___	Cradle Cap	____	____	Heart Murmur			

WHAT IS YOUR INFANT'S / CHILD'S / ADOLESCENT'S DISPOSITION?

____

____

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