

Pediatric Initial Intake

Name: _____ Today's Date: _____ Date of Birth: _____
 Address: _____ Phone #: _____
 Sex: M F Grade in School: _____

Mother's Name & Occupation: _____
 Father's Name & Occupation: _____

Are both Parents actively involved in child's life: Yes No
 Parents are: Married Separated Divorced Living together Other

Concerns in order of importance:
 1. _____
 2. _____
 3. _____
 4. _____

Name of Pediatricians seen: _____
 Date of Last: _____
 What was this visit regarding: Doctor's visit: _____ Blood work: _____ Dental Exam: _____
 Eye Exam: _____
 Has child had any bloodwork done? If yes, please list: _____
 Current medications and supplements (include dosage): _____

Previous hospitalizations and surgeries (include date): _____

Allergies (food/medicine): _____

Family History:

Family Member	Age if Living	Age of Death	Illness(es)/Reason of Death
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Siblings			
Children			

Disease	Family Member
Heart attack/stroke	
Cancer (include type)	
Mental Illness	
Heart Disease	
High Blood Pressure	
Obesity	
Osteoporosis	
Asthma/allergies	
Autoimmune(RA,Lupus,etc)	

Diabetes _____

Vaccination History:

Please indicate if Yes (Y), No (N) or had Some (S)—did not finish all shots:

MMR: Y N S Hemophilis (Hib): Y N S DPT: Y N S
Polio: Y N S Chicken Pox: Y N S Hepatitis B: Y N S

Other Vaccinations: _____

Pregnancy History:

Mother's age at conception: _____ Previous Pregnancies: Y N Alcohol: Y N Smoking: Y N
Recreational Drugs: Y N Nausea/Vomiting: Y N Emotional Stress: Y N Gestational Diabetes: Y N
Preeclampsia: Y N Vaginal Birth: Y N Length of Labor: _____
Complications of Pregnancy: _____
Child's Health at Birth: _____

Previous Medical History:

Child Breast Fed: Y N For how long: _____ Age when Formula: _____ Type of Formula: _____
When were they put on solid food: _____ Walk: _____ Talk: _____ Teeth: _____
Hearing tests normal: Yes No Not tested Vision tests normal: Yes No Not tested
Any speech impediments: Yes No Past Learning impediments: Yes No Past

Indicate yes (Y), No (N), or past (P):

Jaundice	Y	N	P	Cradle Cap	Y	N	P	Eczema/Psoriasis	Y	N	P
Diarrhea	Y	N	P	Constipation	Y	N	P	Finicky Eater	Y	N	P
Poor teeth	Y	N	P	Chronic Sniffles	Y	N	P	Bad Feet Odor	Y	N	P
Very Sweaty	Y	N	P	Growing Pains	Y	N	P	Hyperactivity	Y	N	P
Colic	Y	N	P	Bed wetting	Y	N	P	Early Puberty	Y	N	P
Anemia	Y	N	P	Tantrums	Y	N	P	Stomach Aches	Y	N	P
Asthma	Y	N	P	Disobedient	Y	N	P	Abnormal Vision	Y	N	P
Warts	Y	N	P	Fears/phobia	Y	N	P	Abnormal Hearing	Y	N	P
Nightmares	Y	N	P	Diaper Rash	Y	N	P	Abnormal Speech	Y	N	P
Ear Infections	Y	N	P	Strep Throat	Y	N	P	Learning Problems	Y	N	P

How many times has the child been on Antibiotics: _____

Any particular household stressors child has witnessed or gone through: _____