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PEDIATRIC INTAKE

Patient's Name: ___________________________ Age: ____ Sex: ___ Date of Birth: ___________

Mother's Name: ___________________________ Father's Name: ___________________________

Home Address: ____ Postal Code: __________________

Home Phone: ______________________________ Work Phone: _____________________________

Cell Phone: _______________________________ e-mail: ___________________________________

Referred by: _____________________________

Presenting Health Concerns: ____

____

Medical History- Childhood Illnesses:

Chicken Pox	____	Allergies	____	Tonsillitis (#)	____
Measles	____	Pneumonia	____	Ear Infections(#)	____
Mumps	____	Frequent Cold/Flu	____	Croup	____
Rubella	____	Whooping Cough	____	Asthma	______
Bronchitis	______	Others:			

____

Has your child had any of the following tests? Results

Electorencephalogram: _______________________
Psychological Evaluation:_____________________
Hearing: ___________________________________
Speech/Language: ___________________________

Injuries/Surgeries/Hospitalizations (please list): ____

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Immunizations:

DPT	____	Hep B	______	Men-C	_____
Hib	____	Chicken Pox	______	Flu	_____
MMR	____	Pneumo	_____		

Tylenol given before and/or after vaccines? ____
Adverse Reactions to any vaccine? ____

Mother's Health History:

Previous pregnancies by natural mother _______________Miscarriages? ______________________
Mother's age at child's birth ____________

Mother's health during pregnancy:

Bleeding	____	Physical or emotional trauma	_____	Diabetes	_____
Nausea	____	Cigarettes, alcohol, drug consumption	_____	Anemia	_____
Illnesses	____	Thyroid imbalances	______	Hypertension	_____

Medications taken during pregnancy ____

Birth History:

Term: Full ____ Premature ____ Late ____ Weight at Birth _______________
Induced Labor? ____________Length of Labor ______________ Delivery _____________________

Complications ____
____

Breast fed? ___________ Complications? ___________________How long? ___________________
Formula? _______ *milk or soy* Began at what age?__________Intolerances to Formula?________
Age began solid foods ________ Food Intolerances (if known) _______________________________

Milestones: Sitting ________ Crawling ________ Walking ________ First Words ________
Child's sleep patterns (first year) ____

Child's Medication History:

Tylenol	Bronchodilators	Others:
Antibiotics	Hydrocortisone Creams	
Anti-Histamines	Antacids (Losec, Zantac)	

Symptoms: Mark (C) for current and (P) for past symptoms:

____Eczema	_______ Bed wetting	_______Constipation	_______Fatigue
____Hives	_______ Nightmares	_______ Diarrhea	_______ Wheezing
____Dry skin	_______ Night terrors	_______ Parasites	_______ Asthma
____ Chronic rash	_______ Night sweats	_______ Gas	_______ Cries easily
____ Sore throats	_______ High fevers	_______ Painful urination	_______ Teeth grinding
____ Cavities	_______ Body odour	_______ Bladder infection	_______ Weight loss
____ Cough	_______ Bleeding gums	_______ Nosebleeds	_______ Headaches
____ Frequent colds	_______ No appetite	_______ Joint pains	_______ Anxiousness
____ Sensitive to lights	_______ Bruises easily	_______ Stomach aches	_______ Unusual fears
____ Vomiting spells	_______ Hearing loss	_______ Low muscle tone	_______ Anemia
____ Jaundice	_______ Colic	_______ Seizures	_______ Allergies

Family History (parents, siblings, grandparents):

Allergies	Cancer	Diabetes	Heart Disease
Birth Defects	Alcoholism	Thyroid Disorders	Asthma
Arthritis	Mental Illness	Ulcerative Colitis/Crohn's	Heart Disease