Pediatric Intake & History

PATIENT INFORMATION

Name: ______________________________________

Address: ____________________________________

City: _____________________________ State: _____

Home Phone: ________________________________

Email: _______________________________________

Sex: □ Male □ Female □ Other

Date of Birth: _________________________________

Emergency Contact

Name: _______________________________________

Relationship: __________________________________

Contact Number: _______________________________

Guardian 1 Name: __________________

Relationship: _______________________

Guardian 1 Occupation: ______________

Guardian 1 Phone: __________________

Guardian 1 Email: ___________________

Guardian 2 Name: __________________

Relationship: _______________________

Guardian 1 Occupation: ______________

Guardian 2 Phone: __________________

Guardian 2 Email: ___________________

HOW CAN WE HELP

□ 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: ______________________

____

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 □ Respiratory distress □ Congenital Anomalies □ Extended hospitalization

□ Meconium □ Failure to thrive □ Jaundice □ Other: __________________

____

CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Has your child had? (check all that apply)

□ Chicken Pox □ Measles □ Rubeola

□ Mumps □ Rubella □ Pertussis/Whooping Cough

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

□ Allergies □ Broken Bones □ Digestive issues □ Hypertension □ Orthopedic Problems

□ Anemia □ Chronic Ear Aches □ Juvenile RA □ Paralysis □ Arm Problems

□ Colds/Flu □ Dizziness □ Poor Appetite □ Asthma □ Colic

□ Fainting □ Joint Problems □ Rupture/Hernias □ Back Aches □ Convulsions/Seizures

□ Headaches □ Leg Problems □ Sinus trouble □ Bed Wetting □ Delayed Speech

□ Heart Trouble □ Neck Problems □ Tuberculosis □ Diabetes □ Neuritis

□ Hyperactivity □ Walking Problems □ Behavioral 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: ______

Children's health concerns: _________ Health concerns regarding this pregnancy? ____________

_______________________________ ____

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: _______