PEDIATRIC INTAKE FORM (6-12 years)

Name _____ Date _____

Age ____ Date of Birth __/____/____ female _____ male _

Mother's name _____ Father's name_____

Address _____

City _____ State _____ Zip Code _____

Telephone # (home)_____

How did you hear about this clinic _____

HEALTH HISTORY QUESTIONNAIRE

What are your child's most important health problems? List as many as you can in order of importance.

1)_____

2)_____

3)_____

4)_____

Does your child have a contagious disease at this time? Y N

If yes, what? _____

Previous Illnesses

Rheumatic fever	Y N	German measles	Y N
Chicken pox	Y N	Measles	Y N
Tonsillitis	Y N	approx. number _____	
Ear infections	Y N	approx. number _____	
Other	Y N	list _____	

Hospitalizations/ Surgeries/ Injuries

What hospitalizations, surgeries or injuries has your child had?

_____

_____

Immunizations

Polio	Y N	Pertussis	Y N
Tetanus shot	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Influenza	Y N
Any adverse reactions?	Y N	If yes, what ? _____	

Allergies

Is your child hypersensitive or allergic to:

Any drugs?_____

Any foods? _____

Any environmentals?_____

Breast fed? _____ how long? _____ Formula? ____ milk / soy ____

Typical Food Intake

Breakfast:_____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Please list **any** prescription medications, over the counter medications, vitamins or other supplements your child is taking.

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

REVIEW OF SYSTEMS

Y = a condition now **P** = a condition in the past **N** = never had

MENTAL/ EMOTIONAL

Mood Swings	Y P N	Anxiety/nervousness	Y P N
Irritability	Y P N	Cries easily	Y P N
Hyperactivity	Y P N	Unusual fears	Y P N
Introvert/extrovert	Y P N	Sleep problems	Y P N
Motion/car sickness	Y P N	Nightmares	Y P N

ENDOCRINE

Heat/cold intolerance	Y	P	N	Fatigue	Y	P	N
Excessive thirst	Y	P	N	Excessive hunger	Y	P	N
Low blood sugar	Y	P	N	High blood sugar	Y	P	N

SKIN

Rashes	Y	P	N	Eczema, Hives	Y	P	N
Acne, Boils	Y	P	N	Itching	Y	P	N

HEAD

Headaches	Y	P	N	Head Injury	Y	P	N
Dizzy spells	Y	P	N	High fevers	Y	P	N

EYES

Glasses or contacts	Y	P	N	Tearing or dryness	Y	P	N
Eye pain/strain	Y	P	N				

EARS

Earaches	Y	P	N	Impaired hearing	Y	P	N

NOSE AND SINUSES

Frequent colds	Y	P	N	Nose Bleeds	Y	P	N
Stuffiness	Y	P	N	Hayfever	Y	P	N
Sinus problems	Y	P	N	Loss of smell	Y	P	N

MOUTH AND THROAT

Frequent sore throat	Y	P	N	Canker sores	Y	P	N
Breath odor	Y	P	N				

RESPIRATORY

Cough	Y	P	N	Wheezing	Y	P	N
Asthma	Y	P	N	Bronchitis	Y	P	N

Y = a condition now **P** = a condition in the past **N** = never had

CARDIOVASCULAR

Heart disease	Y	P	N	Murmurs	Y	P	N

URINARY

Frequent urination	Y	P	N	Bed wetting	Y	P	N

GASTROINTESTINAL

Belching/passing gas	Y	P	N	Stomach aches	Y	P	N
Constipation	Y	P	N	Diarrhea	Y	P	N

Bowel Movements How often _____

MUSCULOSKELETAL

Joint pain/stiffness Y P N Muscle spasms/cramps Y P N
Broken bones Y P N

BLOOD/PERIPHERAL VASCULAR

Anemia Y P N Easy bleeding/bruising Y P N

Is there any information about your child's health that you would like to add? ____

_____

_____

_____

_____

Welcome! We're glad to be of service for you and your child!