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**PEDIATRIC INTAKE FORM (6-12)**

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ female \_\_\_\_\_ male \_\_\_\_\_

Mother's name \_\_\_\_\_ Father's name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone # (home) \_\_\_\_\_ email \_\_\_\_\_

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	_____

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Has your child had any of the following tests?      When   Where  
Electroencephalogram (EEG)

.....  
Psychological evaluation

.....  
Hearing tests

.....  
Speech/Language tests

**Hospitalizations/ Surgeries/ Injuries**

What hospitalizations, surgeries or injuries has your child had?

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**Immunizations**

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

**Allergies**

Is your child hypersensitive or allergic to?

Any drugs? \_\_\_\_\_

Any foods? \_\_\_\_\_

Any environmental? \_\_\_\_\_

Breast fed? \_\_\_\_\_ how long? \_\_\_\_\_ Formula? \_\_\_\_\_ milk/soy \_\_\_\_\_

**Typical Food Intake**

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

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
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### NOSE AND SINUSES

Frequent colds	Y P N	Noses Bleeds	Y P N
Stuffiness	Y P N	Hay fever	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= 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!**