P E D I A T R I C   I N T A K E   F O R M

Parent/Guardian, please take the time to accurately complete this form. The information you contribute is valuable in providing effective health care for your child.

Name: ______________________________ Date: ______________

Parent/Guardian: ____

Phone: __________________ Cell: ________________________

Address: ____

Age: __________ Date of Birth: ____________

Weight: ____________ Height: ____________

What are your chief concerns regarding your child's health?

____

____

____

If there is a specific condition, when did it start?

____

____

List practitioners seen for this condition:

____

____

Is there a family history of this condition?

____

____

List any supplements, medications, homeopathic/botanical preparations your child is currently taking, including dosage and duration:

____

____

List any major illnesses, surgeries, hospitalizations, x-rays your child has received. Please include dates:

____

____

____

____

When was your child last well? ______________________________

Has your child ever had any of the following conditions?

- ☐ Rubella (German Measles)
- ☐ Whooping Cough
- ☐ Chicken Pox
- ☐ Strep Throat
- ☐ Measles
- ☐ Scarlet Fever
- ☐ Mumps
- ☐ Impetigo
- ☐ Roseola
- ☐ Mononucleosis
- ☐ Ear Infections

FAMILY HISTORY

Please check appropriate box and indicate which family member:

Disease	Family Member
☐ Alcoholism	____________
☐ Allergies	____________
☐ Arteriosclerosis	____________
☐ Arthritis	____________
☐ Asthma	____________
☐ Bed Wetting	____________
☐ Birth Defects	____________
☐ Cancer	____________
☐ Cataracts	____________
☐ Celiac Disease	____________
☐ Colitis	____________
☐ Depression	____________
☐ Diabetes	____________
☐ Epilepsy	____________
☐ Heart Disease	____________
☐ Hyperactivity	____________
☐ Kidney Disease	____________
☐ Learning Disability	____________
☐ Mental Disease	____________
☐ Muscular Dystrophy	____________
☐ Multiple Sclerosis	____________

FAMILY HISTORY CONTINUED

Please check appropriate box and indicate which family member:

	Disease	Family Member
☐	Schizophrenia	______
☐	Stomach Ulcers	______
☐	Stroke	______
☐	Tuberculosis	______
☐	Yeast Infections	______
☐	Venereal Disease	______
☐	Other*	______
	* ______	______
	______	______

PRENATAL HISTORY

Mother's age at child's birth: ______

Please check appropriate boxes regarding mother's pregnancy:

- ☐ Alcohol Use
- ☐ Bleeding
- ☐ Cigarette Use
- ☐ Diabetes
- ☐ Drug Use
- ☐ Hypertension
- ☐ Illnesses
- ☐ Nausea
- ☐ Medications
- ☐ Physical or Emotional Trauma
- ☐ Thyroid Problems

List any supplements/vitamins taken during pregnancy:

______

______

______

Did the mother smoke before pregnancy? If so, How much?

______

Does anyone in the household currently smoke?

______

Mother's diet during pregnancy was: poor fair good excellent

Mother's emotional state during pregnancy was: poor fair good excellent

BIRTH HISTORY

Full Term Premature: ________ weeks Late: __________ weeks

How was the birth? Please state whether home/hospital, vaginal/C-section, any interventions (forceps, epidural, etc.), any complications:

____

____

____

Child's birth weight: _______________ Length: ___________________

Length of labor: ___________________

Check any of the following if they occurred at birth or soon after:

- ☐ Birth Defects
- ☐ Birth Injuries
- ☐ Colic
- ☐ Jaundice
- ☐ Rashes
- ☐ Seizures

GENERAL INFORMATION

Child's sleep patterns in the first year: ______________________________

____

Child's present sleep patterns: ______________________________

____

Does your child: wake early have difficulty falling asleep have nightmares/terrors

Feeding: breast-fed, How long? _______________ Formula dairy / soy (please circle)

What solid foods were started prior to 6 months of age?

____

____

List your child's favorite foods:

List any food sensitivities/allergies:

Does your child like to cook? __________ How often? ________________

Describe a typical day's diet:

Breakfast: ________________

Lunch: ________________

Dinner: ________________

Snacks: ________________

Bowel movements (quantity, color, presence of blood, mucus, undigested food):

Does your child experience any gas, bloating, vomiting, constipation or diarrhea?

Please describe the emotional climate or your home:

How many siblings does your child have (please list ages) and how they interact:

Thank you for taking the time to complete this form.