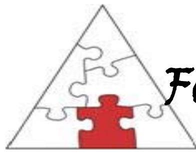

Foundation for Integrated Health

Pediatric Intake Form

General Information
Child's name: ________________________________ Date of first visit: _____________
Child's Age: ________ Date of Birth: ______/______/______ Gender: F M
MSP #____________________ Child's grade level________
Who is filling out this form? (name and relationship) ____________________________
Who does this child live with? ____
How did you hear about the clinic? ____

Guardian Contact Information:
Mother's name:__________________________ Father's name: ___________________________
Address: ____
Phone # (home): (______)________________ Parents # (work): (______)________________
Parents e-mail address: ____
Name of Dr.'s Office/Hospital/Clinic where your child's health records are kept: ____________
____

Does your child have any known contagious diseases at this time?
No Yes: ____

MEDICATIONS	Now	Past		Now	Past
Aspirin	_______	_____	Antibiotics	_______	_____
Tylenol	_______	_____	Anti-histamine	_______	_____
Decongestant	_______	_____	Other	_______	_____
Ibuprofin	_______	_____	Allergies to medicines ____________________		

MEDICAL HISTORY
_______ Chicken pox _ Scarlet fever _______ Tonsillitis, approx. no. ________________
_______ Measles _______ Pneumonia _______ Ear infections, no. _______________
____
_______ Mumps _______ Frequent colds _______ other (please list) _______________
____
_______ Rubella _______ Rheumatic fever

Has your child had any of the following tests? When Where Results
Electroencephalogram...
Psychological evaluation...
Hearing...
Speech/Language...
Injuries/Surgeries/Hospitalizations (please list): ____
____

IMMUNIZATIONS
______ Measles ______ Polio ______ MMR ______ Smallpox ______ Diphtheria
______ Mumps ______ DPT ______ Tetanus ______ Influenza
Others (list) ____
Any adverse reactions? Y N What ? ____

FAMILY HISTORY
______ Heart disease ______ Diabetes ______ Birth defects
______ Hypertension ______ Arthritis ______ Tuberculosis
______ Cancer ______ Allergies ______ Mental illness

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications? ___________________

____

Mother's age at child's birth? ____________

Mother's health during pregnancy?

______ Bleeding	______ Physical or emotional trauma	
______ Nausea	______ Cigarettes, alcohol, drug consumption	
______ Illnesses	______ Medications	
______ Hypertension	______ Thyroid problems	______ Diabetes

BIRTH HISTORY

Term: Full _________ Premature ___________ Late _____________ Weight at birth____________ _______

Length of labor __________________ Complications? __________________________________

Did your child have any of the following problems shortly after birth?

_______ Birth defects	_______ Birth injuries	_______ Blue baby
_______ Cerebral palsy	_______ Seizures	_______ Jaundice
_______ Colic	_______ Fever	_______ Rashes

Other (explain) ____

Child's sleep patterns (first year) ____

Food intolerances (if any) ____

Feeding: Breast-fed? _________ How long? _______________ Formula? _ Milk / soy _________

Age began solids _______________________ which foods? _________________________________

Age began: Sitting __________ Crawling __________ Walking ____________ Talking _________

SYMPTOMS (mark **Y** if current, **P** significant past symptom)

_______ Hives	_______ Burning of urine	______ Bloody urine
_______ Eczema	_______ Frequent urination	______ Cries easily
_______ Bleeding gums	_______ Heart murmur	______ Nervous
_______ Nose bleeds	______ Vomiting spells	______ Sleep problem
_______ Acne	_______ Anemia	______ Night sweats
_______ High fevers	_______ Stomach aches	______ Sensitive light
_______ Chronic rash	_______ Jaundice	______ Body/breath or
_______ Hearing loss	_______ Easy bruising	______ Motion/car sickness
_______ Diarrhea	_______ Flat feet	______ No appetite
_______ Sore throats	_______ Constipation	______ Nightmares
_______ Headaches	_______ Gas	______ Canker sores
_______ Frequent colds	_______ bleeding tendency	______ unusual fears
_______ Wheezing	_______ Joint pains	______ Xs fatigue
_______ Cough	_______ Dizzy spells	______ Hair loss

DIET

Please describe your child's typical daily diet:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

To Drink: ____