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Pediatric Intake Form

Today's Date:	Email:	

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:
Sex: ☐ Male ☐ Female	Birth Date: / /	Age:

PARENT/RESPONSIBLE PARTY INFORMATION

Parent/Responsible Party:		Phone #: ( )
Street Address:	P.O. Box:	
City:	State:	ZIP Code:

Referred by: ☐ Dr. ☐ Internet ☐ Hospital ☐ Family ☐ Friend ☐ Yellow Pages ☐ Other

Other family members seen here:

CURRENT HEALTH CARE TEAM

Pediatrician:		Phone #: ( )
Specialty Doctor:	Type of care:	Phone #: ( )
Specialty Doctor:	Type of care:	Phone #: ( )
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Pediatric Intake Form (page 1)

Name (Last, First, M.I.): | Birth Date: / /

Reason for this visit?

Duration of complaints/symptoms:

Any other associated complaints/symptoms?

What has been done so far?

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS: *(i.e. vitamins, inhalers, etc.)*

DRUG/VITAMIN NAME	STRENGTH	DOSE/FREQUENCY TAKEN

Has the child had the following tests? *(Please list the dates and results, if known)*

☐ EEG: | ☐ CT Scan: | ☐ Drug Levels:

Any other important tests:

PAST MEDICAL HISTORY/INFECTIONS:

Duration of pregnancy: | Birth Weight:

Any complications during pregnancy?

Any drugs taken during pregnancy?

Any alcohol? | How much? | Any tobacco? | How much?

High blood pressure?

Illnesses/Infections during pregnancy?

LABOR AND DELIVERY:

How long was labor? | Breech or unusual presentation?

Cesarean birth? | Reason:

Pain medication used? | Pitocin used?

Forceps used? | Delay in respiration or cry?

Was oxygen administration necessary? | Type of anesthesia employed for mother?

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Pediatric Intake Form (page 2)

NEWBORN:

☐ Jaundice	☐ Cyanosis
☐ Infection	☐ Seizures
☐ Anemia	Home from hospital in how many days?

Other important conditions:

DEVELOPMENT: *(Write age beside development)*

	Smile		Crawled
	Laughed out loud		Pulled to stand
	First words		Walked around furniture
	First words put together *(e.g. "daddy", "bye-bye")*		Walked unassisted
	Completed sentences		Tied shoelaces
	Rolled over		Toilet trained
	Sat without support		

ILLNESSES:

AGE:	REASON FOR HOSPITALIZATION:

Any history of head injury?

Has the child ever been unconscious?

SEIZURE HISTORY:

Has your child ever had a convulsion?

With fever?	Ages:
Without fever?	Ages:

Does the child daydream often?

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Pediatric Intake Form (page 3)

FAMILY HISTORY: *(Any family history of the following)*

- ☐ Allergies *(specify)*
- ☐ Asthma
- ☐ Cardiovascular disease
- ☐ Diabetes
- ☐ Seizures
- ☐ Other neurological *(specify)*
- ☐ Musculoskeletal condition *(specify)*
- ☐ Autoimmune disease *(specify)*
- ☐ Cancer *(specify)*
- ☐ Skin disorder *(specify)*
- ☐ Migraines
- ☐ Other significant health problems:

SCHOOL ASSESSMENTS: *(According to the parents)*

Reading level:

Motivation:

Behavior:

Attention:

Relationship with teachers/peers:

Achievements:

Eyesight:

Hearing:

Motor coordination:

Speech:

Other health problems:

Any known allergies?

Previous complications of any therapy?

Has your child received the standard vaccination schedule?

Any additional vaccines?

QUESTIONS THAT YOU WANT ANSWERED DURING THIS EXAMINATION:

ANY ADDITIONAL INFORMATION: