PEDIATRIC COVER SHEET

Today's Date ____________

YOUR CHILD

Child's Name: ____ Nickname: _________________________

Birth date ____________________________ Age __________________ Sex: ☐ Male ☐ Female

School ____ Grade ___________

Child's Home Address ____

City, State, Zip _____________________________________ Phone _____________________________

RESPONSIBLE PARTY

Name ____ Relationship __________________________

☐ **Mother** ☐ Stepmother ☐ Guardian

Name ____

Address, if different ____

____

Employer ____ Occupation ______________________

Phone: Home ______________________ Work __________________ Cell ________________

☐ **Father** ☐ Stepfather ☐ Guardian

Name ____

Address, if different____

____

Employer ____ Occupation ______________________

Phone: Home ______________________ Work __________________ Cell ________________

Parents are: ☐ Married ☐ Separated ☐ Divorced ☐ Living together ☐ Other

Who is responsible for making appointments?____

Best time to call ____

PEDIATRIC INTAKE FORM (BIRTH TO 10 YEARS)

Patient's Name: ____ Date: _________________
Age: _________ Date of Birth: ________________________________Gender: Female / Male
Parent/Guardian's Name: _____________________________________
Address: ____
City: ____________________________________ State: ________________ Zip: __________
Telephone (home): ______________________________ (Parent's Work):_________________
Parent's email address: ____
How did you hear about this clinic?
____
If internet: Google:____ AANP Website:____ OANP Website:____
Other:________________________
Has any other family member already been a patient at this clinic?_______________________
Name of doctor's office/hospital/clinic where your child's health records are
kept:____
____
Reason for referral or presenting problems:
____
____
____

MEDICATIONS

NOW	PAST		NOW	PAST	
____	____	Aspirin	____	____	Decongestants
____	____	Tylenol	____	____	Anti-histamine
____	____	Antibiotics	____	____	Other ____________________________
____	____	Ibuprofen			

Allergies to medicines: ____

MEDICAL HISTORY

____ Chicken pox	____ Scarlet fever	____ Tonsillitis, approx no. of times: _________
____ Measles	____ Pneumonia	____ Ear infections, approx no. of times:_______
____ Mumps	____ Frequent colds	____ Strep throat, approx no. of times: _______
____ Rubella	____ Rheumatic fever	____ Other: ____________________________

Has your child ever had any of the following? WHEN WHERE RESULTS
Electroencephalogram (EEG):
____

Psychological evaluations:____

Hearing test: ____

Speech/language tests: ____

Injuries/surgeries/hospitalizations (please list):
____
____
____

IMMUNIZATIONS
____ MMR ____ DPT ____ Chicken pox
____ Measles ____ Diphtheria ____ Small pox Adverse reactions: Y / N
____ Mumps ____ Tetanus ____ H. influenza If so, what? ______________________
____ Rubella ____ Polio ____ The flu (Type)___________________________________
Others:____

FAMILY HISTORY
____ Heart disease ____ Diabetes ____ Birth defects
____ Hypertension ____ Arthritis ____ Tuberculosis
____ Cancer ____ Allergies ____ Asthma
____ Mental illness ____ Osteoporosis ____ Other significant:
____

PRENATAL HISTORY
Previous pregnancies by natural mother, miscarriages, or complications?
____
____
____
Mother's age at child's birth: ______
Mother's health during pregnancy:
____ Bleeding ____ Nausea ____ Physical or emotional trauma
____ Illnesses ____ Hypertension ____ Cigarettes, alcohol, drug consumption
____ Medications ____ Diabetes ____ Thyroid problems

BIRTH HISTORY
Term: ____ Full ____ Premature ____ Late
Weight at birth: ____
Length of labor: ____
Complications:____
Did you child have any of the following problems shortly after birth?
____ Rashes ____ Birth injuries ____ Blue baby
____ Jaundice ____ Seizures ____ Cerebral palsy
____ Colic ____ Fever ____ Birth defects
____ Other: ____

Child's sleep patterns (1st year):
____

Food intolerances:
____

Breast fed: Y / N How long: __________ Formula: Y / N Type (milk, soy):_________________

Age began solids: _________ Which Foods:____

Age began: Sitting _________ Crawling _________ Walking _________ Talking ___________

SYMPTOMS

____ Hives	____ Burning urine	____ Bloody urine	____ Eczema
____ Cries easily	____ Bleeding gums	____ Heart murmur	____ Nervous
____ Nose bleeds	____ Vomiting spells	____ Sleep problems	____ Asthma
____ Acne	____ Anemia	____ Night sweats	____ High fevers
____ Jaundice	____ Sensitive to light	____ Chronic rash	____ Stomach aches
____ Diarrhea	____ Hearing loss	____ Easy bruising	____ Sore throats
____ Flat feet	____ No appetite	____ Constipation	____ Body/breath odor
____ Nightmares	____ Frequent colds	____ Unusual fears	____ Bleeding tendency
____ Wheezing	____ Joint pains	____ Cough	____ Excessive fatigue
____ Dizzy spells	____ Hair loss	____ Allergies	____ Frequent urination

DIET

Please describe your child's typical daily diet:

Breakfast:
____

Lunch:
____

Dinner:
____

Snacks:
____

To drink:
____

THANK YOU. WE LOOK FORWARD TO HELPING YOUR CHILD IN ANY WAY WE CAN.