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CHILD INTAKE FORM

Date _____

Name _____ Date of Birth _____

Address _____

Mother's Name _____ Phone (h) _____ (w) _____

Father's Name _____ Phone (h) _____ (w) _____

Other Contact?_____ Phone (h) _____ (w) _____

Please list members of child's household (including name, relationship, and age if child)

_____

_____

Other Health Care Providers

Name	Title	Location	Phone

What are the child's main health concerns?

_____

_____

_____

_____

How would you describe his/her overall state of health?

___ very poor ___ poor ___ fair ___ good ___ very good ___ excellent

Current weight _____ height _____

List any accidents, injuries, hospitalizations (including type and year of occurrence)

_____

_____

List any known allergies (including food, drugs, insects, herbs, environmental)

_____

_____

List any abnormal test results that you are aware of

_____

_____

Current Medications & Supplements

Name (Brand)	Daily Dose	Name (Brand)	Daily Dose

Immunizations _____

Any reactions to vaccines? _____

Has child ever taken antibiotics? (Y/N) ____ Approximate number of times _____

Has child ever taken corticosteroids? (Y/N) ____ Approximate length of time _____
(e.g. prednisone, hydrocortisone cream, inhaler for asthma)

Any other medications in the past? _____

Family History

Indicate if a close relative (parent, siblings, grandparents) has had any of the following:

Allergies		Mental Illness	
Asthma		Heart Disease	
Eczema		Cancer	
Birth defects		Kidney Disease	
Tuberculosis		Other:	
Diabetes		Other:	

Prenatal Health

Mother's age while pregnant _____

Please summarize prenatal care (e.g. physician visits, ultrasound, other tests)

_____

_____

List any medications and/or supplements taken during pregnancy

_____

Any of the following during pregnancy?

___ bleeding ___ vomiting ___ tobacco use ___ emotional trauma
___ diabetes ___ high blood pressure ___ physical trauma ___ significant stress
___ nausea ___ thyroid problems ___ infection

Other/comments: _____

Birth History

Term length _____ Early or late? _____ Weight at birth _____

Where was child born? _____ APGAR score(s)? _____

Was the delivery: _____ Vaginal _____ Caesarian _____ Induced _____ Forceps

Was anesthesia used? _____ Any other interventions? _____

Any of the following at or shortly after birth?

____ birth injuries ____ jaundice ____ seizures ____ rash ____ colic ____feeding problems

Other/comments _____

Symptoms, Illnesses

Indicate with a "C" if child is experiencing any of these, and "P" if he/she did in the past:

___ acne ___ cough ___ freq. urination ___ muscle pains
___ allergies ___ diarrhea ___ gas/flatulence ___ night sweats
___ anemia ___ dizzy spells ___ hair loss ___ nosebleeds
___ asthma ___ easy bleeding ___ hearing loss ___ seizures
___ bleeding gums ___ easy bruising ___ heart murmur ___ sore throat
___ blood in urine ___ eczema ___ high fever ___ stomach aches
___ burning urination ___ fatigue ___ hives ___ vomiting
___ chronic rash ___ flat feet ___ jaundice ___ wheezing
___ colic ___ freq. colds ___ joint pains ___ sleep problems
___ constipation ___ freq. headaches ___ motion sickness ___ nightmares

___ chicken pox ___ rubella ___ Strep throat ___ tonsillitis
___ measles ___ scarlet fever ___ rheumatic fever ___ ear infection(s)
___ mumps ___ pneumonia ___ fifth disease ___ flu

Other/comments _____

Diet

First Year: Breast fed? _____ How long? _____

Formula fed? _____ How long? _____ Type _____

Foods introduced during first year _____

_____

Current: Breakfast _____

Lunch _____

Supper _____

Snacks _____

Beverages _____

Favorite foods _____

Disliked foods _____

How would you describe the child's:

personality? _____

_____

behavior and performance at school? _____

interaction with other children? _____

interaction with adults? _____

What are his/her favorite activities? _____

_____

Is there anything else you feel I should know? _____

_____

_____