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Pediatric Intake Form

Today's Date _____

Child's Name: _____

Parent/s Name/s: _____ E-mail address _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____

Child's Date of Birth: _____ Age: _____

Person to Contact in Case of Emergency

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

How were you referred to Dr. Phillips? _____

What are your child's most important health problems? Please list in order of importance, so that the health problems you want to address first are listed first.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

Medications & Supplements (List all prescription and non-prescription drugs, dosages and length of time you have been taking these medications):

Currently, who is the child's primary care physician?

When was the child's last physical exam?

Childhood Illnesses:

Chicken pox

Scarlet Fever

Mononucleosis

Measles

Rheumatic Fever

Ear Infections

Mumps

Strep Throat

Tonsillitis

Rubella

Pneumonia

Croup

Whooping Cough

Asthma

Other _____

Immunizations? Yes or No

Standard or Additional (foreign travel, etc)

Adverse Reactions? List below:

Were adverse reactions reported to the CDC?

Hospitalizations, Surgeries, Accidents, Serious injuries

Describe any incidences and provide dates:

Family History: Identify all family members who have or have had any of the following:

_____ Alcoholism

_____ Cancer

_____ High Blood Pressure

_____ Allergies

_____ Diabetes

_____ Hypoglycemia

_____ Anemia

_____ Eczema

_____ Mental Illness

_____ Arthritis

_____ Epilepsy

_____ Obesity

_____ Asthma

_____ Heart Disease

_____ Stroke

_____ Birth Defects

_____ Hearing Loss

_____ Thyroid disorder

_____ Other (describe):

CHILD'S HEALTH HISTORY

Please check:

NOW PAST

___ ___ Acne

___ ___ Allergies

___ ___ Anemia

___ ___ Asthma

___ ___ Bed Wetting

___ ___ Birth Defects

___ ___ Colic

___ ___ Cough/Wheeze

___ ___ Cradle Cap

___ ___ Depression

___ ___ Diarrhea/Constipation

___ ___ Dizziness

___ ___ Earaches

___ ___ Eczema

NOW PAST

___ ___ Epilepsy/Seizures

___ ___ Fatigue

___ ___ Frequent Infections

___ ___ Headaches

___ ___ Heart Murmur

___ ___ High Fever

___ ___ Hyperactivity

___ ___ Insomnia

___ ___ Learning Disorder

___ ___ Moodiness

___ ___ Stuffy Nose

___ ___ Thrush

___ ___ Vomiting spells

PRENATAL/BIRTH/FEEDING HISTORY:

Mother's Health during pregnancy with this child- describe briefly any complications:

Term: ___ Full ___ Premature ___ Late Birth weight: ___

Place of Birth: home/hospital/birthing suite/other

Feeding: Breast duration ___ Formula duration ___ Age solids introduced ___

DIET

Food intolerances/allergies? List _____

Diet eaten yesterday:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

SOCIAL HISTORY:

Parents: Married/Separated/Divorced (circle one)

Occupation: Mother _____ full/part (circle one)

Father _____ full/part (circle one)

Others residing in home? _____

Other Guardians? _____

Daycare? If so, where? _____

How many hours per week? _____

Please list siblings below:

NAME

AGE

HEALTH PROBLEMS, if any