Jennifer Phillips, ND

41 W Chestnut Ave, Merchantville, NJ 08109

(856) 488-7067

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. _____ 4. _____

2. _____ 5. _____

3. _____ 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		NOW	PAST	
____	____	Acne	____	____	Epilepsy/Seizures
____	____	Allergies	____	____	Fatigue
____	____	Anemia	____	____	Frequent Infections
____	____	Asthma	____	____	Headaches
____	____	Bed Wetting	____	____	Heart Murmur
____	____	Birth Defects	____	____	High Fever
____	____	Colic	____	____	Hyperactivity
____	____	Cough/Wheeze	____	____	Insomnia
____	____	Cradle Cap	____	____	Learning Disorder
____	____	Depression	____	____	Moodiness
____	____	Diarrhea/Constipation	____	____	Stuffy Nose
____	____	Dizziness	____	____	Thrush
____	____	Earaches	____	____	Vomiting spells
____	____	Eczema			

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