PEDIATRIC/ ADOLESCENT INTAKE FORM

Patient's Name:_____DOB(DD/MM/YY):_____Age:_____

Parent's Names:_____

Address:_____

Home Phone:_____ Work Phone:_____ Cell:_____

May we leave confidential voice-mail messages for you at any of the above numbers?
☐ No ☐ Yes (Please specify): ☐ Home ☐Work ☐ Cell

Emergency Contact: _____ Phone: _____ Relation_____

How did you hear about us? _____

What is your email address? _____

May we send you invoices and appointment reminders via email? ☐Y ☐N Quarterly Newsletters? ☐Y ☐N

Like us on facebook and receive a 10% discount off of your next visit! Make sure to inform the receptionist.

PRESENT HEALTH CONCERNS

Chief Complaint/Reason for Visit:

1) _____ 3) _____

2) _____ 4) _____

What treatment has the patient received for his/her condition? ☐ Medication(s) ☐ Surgery ☐ Other

_____

Name and Number of
General Practitioner/Specialist_____

PATIENT'S MEDICAL HISTORY

☐ Acne	☐ Constipation	☐ Diabetes
☐ Allergies	☐ Cough/ Wheeze	☐ Eating Disorder
☐ Anemia	☐ Cradle Cap	☐ Epilepsy/ Seizures
☐ Asthma	☐ Depression	☐ Exposure to cigarette smoke
☐ Bed Wetting	☐ Diarrhea	☐ Fractures
☐ Birth Defects	☐ Dizzy spells	☐ Frequent Infections
☐ Chicken Pox	☐ Earaches	☐ Headaches/ Migraines
☐ Colic	☐ Eczema	☐ Heart murmur

☐ High Fever
☐ Hyperactivitiy
☐ Insomnia/ sleep problems
☐ Jaundice
☐ Learning disorder
☐ Stuffy nose
☐ Measles
☐ Mononucleosis
☐ Mumps
☐ Pneumonia
☐ Rheumatic Fever
☐ Thrush
☐ Rubella
☐ Scarlet Fever
☐ Strep Throat
☐ Tonsillitis
☐ Vomiting Spells
☐ Other:

Please fill out the following, with approximate age of occurrence, in chronological order.

Any Hospitalizations / Surgery / Serious Illnesses / Dental Interventions

_____

_____

_____

Current Medications/Vitamins/Herbs and doses:

_____

_____

Allergies (drugs, foods, environmental):

_____

_____

FAMILY MEDICAL HISTORY

Please state any medical conditions OR reasons of death of patient's grandparents, parents, and siblings:

_____

_____

_____

PRENATAL/ BIRTH HISTORY

1. Mother's health during the pregnancy with this patient:

Age at

☐ Illness
☐ Trauma/ Injury
☐ Stress
☐ High blood pressure
☐ Gestational diabetes
☐ Toxemia
☐ Alcohol/ drugs/ smoking (please circle)
☐ Other health problems:

2. Term

☐ Premature
☐ Full term
☐ C-section

Birth weight_____

FEEDING HISTORY

☐ Breast fed
☐ Formula fed

Until what age were they breastfed _____

Type of formula_____

Age that solid foods began _____

Which foods_____

Any food allergies or reactions? To what foods?

_____

_____