

Pediatric Health Intake

Name: _____ Date of Birth: _____ Sex: M F Age: _____

Mother's Name: _____ Father's Name: _____

Parents marital status: Married/Separated/Living together/Other Blood Type: ___ Current grade in School: _____

Health Concerns: Please list in order of importance. Rate severity (1 is low, 10 is high) and success (1 is no success, 10 is very successful).

Concern	Severity (1-10)	Past/Present Treatments	Success Level (1-10)

Is the child currently under the care of a physician? Yes/No

Specialty: _____

If yes, with whom? What condition? _____

If no, when did the child last receive medical care? _____

When was the last well-child exam? _____

Does the child have a known infectious disease at this time? Yes/No If yes, what? _____

Any known drug or food allergies? _____

Medications/Supplements

Please list all medications and vitamins/supplements you are currently taking in the following table:

Current

Name	Strength	Dosage	Reason	Duration

Past (Within last six months, circle any that apply)

- | | | | |
|-----------------------|----------------|-----------|---------------|
| Pain Relievers | Birth control | Laxatives | Thyroid |
| Antacids | Blood pressure | Sedatives | Tranquilizers |
| Antibiotics | Hormones | Sleeping | Supplements: |
| Appetite suppressants | Insulin | Steroids | |

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Social History

With whom does the child live? _____ Pets? _____ Indoor/Outdoor

Has the child lived or traveled outside of the United States? _____ If so, when and where? _____

Typical Breakfast		Time
Lunch		Time
Dinner		Time
Snacks		

Food	Servings per Week	Food	Servings per Week
Beef		Fresh Fruit	
Poultry Light		Fresh Vegetables	
Dark		Breads, cereals, grains, pasta	
Lamb		Legumes	
Fish		Seeds	
Pork		Nuts/Nut Butters	
Tofu/Soy Products		Butter (sticks/week)	
Eggs (#/week)		Oils:	
Yogurt %fat			
Protein Powder (type)			
Cottage Cheese %fat		Sweets (cookies, cakes, candy)	
Cheese (oz servings)			

Cravings? _____ Dietary restrictions or food aversions? _____

Time in between meals? _____ Water intake: # _____ oz/day

Organic fruits and vegetables? Yes/No/Some Organic meat and dairy? Yes/No/ Some

Beverages (specify type):

Coffee/Tea: _____ Soda: Diet/Regular Milk: _____ %fat

Regular exercise? Yes/No What kind? _____ Frequency? _____ Duration? _____

Interests and hobbies: _____

Does the child watch television? Yes/No Hours/Night? _____

Sleep

Hours/night: _____ Wake refreshed? Yes/No Fall asleep easily (within 5 min.)? Yes/No

Wake to urinate? Yes/No Wake at other time: _____ Snoring? Yes/No

Stop breathing during sleep? _____ Concerns about sleep: _____

Energy (scale of 1-10, 10 is the best): _____ Stress (scale of 1-10, 10 is most severe): _____

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Family History

	Age if Living	Age of Death	Health Problems (please list any cancers, cardiovascular disease, diabetes, thyroid or osteoporosis)
Mother			
Maternal Grandmother			
Maternal Grandfather			
Father			
Paternal Grandmother			
Paternal Grandfather			
Siblings			

Birth History

Mothers age at conception: _____ Did she have other children? Y or N Number of children in family? _____

Mothers health during pregnancy: (Circle any that apply)

Diabetes	Caffeine	Nausea/Vomiting
Hypertension	Alcohol	Emotional Stress
Smoking	Recreational Drugs	Medications _____

Vaginal or Cesarean birth (Circle). Number of weeks at delivery: _____ Birth Weight: _____

Labor was **Spontaneous or Induced** (Circle). If induced, please explain: _____

Labor is in a **hospital or other** (Circle). If other, please describe: _____

Number of hours of labor: _____ Birth difficulties: _____

Breastfed or Bottle fed (circle). If bottle fed, formula type: _____

If breastfed, for how long? _____

Feeding problems: _____

When was solid food introduced (age): _____

When did the child walk? _____ Talk? _____ Get first teeth? _____

<i>Childhood illnesses</i>	Yes, Had Disease	No, Never Had	Vaccinated
Scarlet Fever			
Mumps			
Diphtheria			
Rheumatic Fever			
German Measles			
Measles			

<i>Childhood illnesses</i>	Yes, Had Disease	No, Never Had	Vaccinated
Chicken Pox			
Shingles			
Smallpox			
Rubella			
Pertussis			
Other			

Other Vaccinations (circle) Polio Tetanus Flu
 Vaccination reactions? _____

Hepatitis B Meningitis HPV

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Surgeries, Hospitalizations and Procedures

Surgery	Year	Reason
Appendectomy		
Tonsillectomy		
Dental		
Gallbladder		
Hernia		
Other		
Artificial joints or other implants?	Yes No Type?	
Hospitalizations	Year	Reason
Diagnostic Procedures	Year	Reason
Ultrasound		
X-Ray		
CT/MRI		Location?

Allergies

	Type	Reaction
Medications		
Foods		
Environmental		

Environmental History

Please indicate (X) if child has any current or past exposure to the items listed in the following table:

Household	Current	Past	Reaction
Leaded paint			
Near refinery or industrial area			
New Carpet/Paint/Other Remodeling			
Pesticide/Insecticide Use			
Dry Cleaning			
Live in a Smoking Home			
Work			
Solvent Exposure			
Heavy Metals			
Fumes			
Chemicals			
Work in Smoking Environment			

Household	Current	Past	Reaction
Sensitivities			
Perfumes			
Detergents			
Gas or other Vapors			
Other			
Radiation			
Infectious			
Does child have metal or mercury fillings? Yes No			
Number?			
Date of last filling:			
How many removed?			
Root canals currently?			
Root canals removed?			

Review of Systems

Please **CIRCLE** from the following options:

Yes (Y)= A condition child has **now** or in the **past 6 months**, No (N)=never had, Past (P)= A condition child had in the past (**longer than 6 months ago**)

<u>Cold Hands and Feet</u>	Y	N	P	<u>Vertigo or Dizziness</u>	Y	N	P	<u>Eye Conjunctivitis</u>	Y	N	P
<u>Daytime Sleepiness</u>	Y	N	P	<u>Loss of Balance</u>	Y	N	P	<u>Crusting</u>	Y	N	P
<u>Difficulty Falling/Staying Asleep</u>	Y	N	P	<u>Fainting</u>	Y	N	P	<u>Impaired Vision</u>	Y	N	P
<u>Early Waking</u>	Y	N	P	<u>Lightheadedness</u>	Y	N	P	<u>Eye Pain/Strain</u>	Y	N	P
<u>Fever</u>	Y	N	P	<u>Loss of Consciousness</u>	Y	N	P	<u>Glasses/Contacts</u>	Y	N	P
<u>Flushing</u>	Y	N	P	<u>Nerve Pain</u>	Y	N	P	<u>Tearing or Dryness</u>	Y	N	P
<u>Sleepwalking</u>	Y	N	P	<u>Tremor</u>	Y	N	P	<u>Double Vision</u>	Y	N	P
<u>Nightmares</u>	Y	N	P	<u>Rash</u>	Y	N	P	<u>Glaucoma</u>	Y	N	P
<u>No Dream Recall</u>	Y	N	P	<u>Eczema</u>	Y	N	P	<u>Cataracts</u>	Y	N	P
<u>Snoring</u>	Y	N	P	<u>Hives</u>	Y	N	P	<u>Eyelid Redness</u>	Y	N	P
<u>Chronic Fatigue</u>	Y	N	P	<u>Acne</u>	Y	N	P	<u>Vision Problems</u>	Y	N	P
<u>Chronic Infection</u>	Y	N	P	<u>Boils</u>	Y	N	P	<u>Muscle Twitch in Eye</u>	Y	N	P
<u>Enlarged/Tender Lymph Nodes</u>	Y	N	P	<u>Itching</u>	Y	N	P	<u>Impaired Hearing</u>	Y	N	P
<u>Slow Wound Healing</u>	Y	N	P	<u>Skin Color Change</u>	Y	N	P	<u>Ringing or Noise in Ear</u>	Y	N	P
<u>Chemical/Metal/Drug Poisoning</u>	Y	N	P	<u>Perpetual Hair Loss</u>	Y	N	P	<u>Earaches</u>	Y	N	P
<u>Hyper/Hypo (circle) Thyroid</u>	Y	N	P	<u>Head Lumps</u>	Y	N	P	<u>Dizziness</u>	Y	N	P
<u>Hot/Cold (circle) Intolerance</u>	Y	N	P	<u>Athletes Foot</u>	Y	N	P	<u>Ear Fullness</u>	Y	N	P
<u>Night Sweats</u>	Y	N	P	<u>Cellulite</u>	Y	N	P	<u>Other Ear Pain</u>	Y	N	P
<u>Hyper/Hypo (circle)glycemia</u>	Y	N	P	<u>Dark Circles Under Eyes</u>	Y	N	P	<u>Sensitivity to Loud Noise</u>	Y	N	P
<u>Diabetes</u>	Y	N	P	<u>Ears/Face (circle) Red</u>	Y	N	P	<u>Frequent Sore Throats</u>	Y	N	P
<u>Excess Thirst</u>	Y	N	P	<u>Moles with Color or Size</u>	Y	N	P	<u>Excess Saliva</u>	Y	N	P
<u>Excess Hunger</u>	Y	N	P	<u>Shange</u>				<u>Dry Mouth</u>	Y	N	P
<u>Fatigue</u>	Y	N	P	<u>Oily Skin</u>	Y	N	P	<u>Teeth Grinding</u>	Y	N	P
<u>Agoraphobia</u>	Y	N	P	<u>Pale Skin</u>	Y	N	P	<u>Gum Problems</u>	Y	N	P
<u>Auditory/Visual (circle) Hallucinations</u>	Y	N	P	<u>Psoriasis</u>	Y	N	P	<u>Hoarseness</u>	Y	N	P
<u>Treatment for Emotional Problem</u>	Y	N	P	<u>Sensitive to Bites</u>	Y	N	P	<u>Sore Tongue</u>	Y	N	P
<u>Difficulty Concentrating</u>	Y	N	P	<u>Shingles</u>	Y	N	P	<u>Coating on Tongue</u>	Y	N	P
<u>Mood Swings</u>	Y	N	P	<u>Skin Cancer</u>	Y	N	P	<u>Loss of Taste</u>	Y	N	P
<u>Considered/Attempted (circle) Suicide</u>	Y	N	P	<u>Skin Darkening</u>	Y	N	P	<u>TMJ Problems</u>	Y	N	P
<u>Memory problems</u>	Y	N	P	<u>Strong Body Odor</u>	Y	N	P	<u>Teeth Problems</u>	Y	N	P
<u>Depression</u>	Y	N	P	<u>Thick Calluses</u>	Y	N	P	<u>Bleeding Gums</u>	Y	N	P
<u>Anxiety/Nervousness</u>	Y	N	P	<u>Vitiligo</u>	Y	N	P	<u>Canker Sores</u>	Y	N	P
<u>Panic Attacks</u>	Y	N	P	<u>Nails Bitten</u>	Y	N	P	<u>Cold Sores</u>	Y	N	P
<u>Fearfulness</u>	Y	N	P	<u>Brittle</u>	Y	N	P	<u>Cracking at Corner of Lips</u>	Y	N	P
<u>Irritability</u>	Y	N	P	<u>Curve Up</u>	Y	N	P	<u>Dentures</u>	Y	N	P
<u>Phobias</u>	Y	N	P	<u>Frayed</u>	Y	N	P	<u>Periodontal Diseases</u>	Y	N	P
<u>Paranoia</u>	Y	N	P	<u>Fungus</u>	Y	N	P	<u>Neck Lumps</u>	Y	N	P
<u>Seizures</u>	Y	N	P	<u>Pitting</u>	Y	N	P	<u>Swollen Glands</u>	Y	N	P
<u>Paralysis</u>	Y	N	P	<u>Ragged Cuticles</u>	Y	N	P	<u>Goiter/Enlarged Thyroid</u>	Y	N	P
<u>Muscle Weakness</u>	Y	N	P	<u>Ridges</u>	Y	N	P	<u>Neck Pain or Stiffness</u>	Y	N	P
<u>Numbness</u>	Y	N	P	<u>Thickening</u>	Y	N	P	<u>Nose Stuffiness</u>	Y	N	P
<u>Tingling</u>	Y	N	P	<u>Toenail Problems</u>	Y	N	P	<u>Sinus Fullness</u>	Y	N	P
<u>Loss of Memory</u>	Y	N	P	<u>White Spots/Lines</u>	Y	N	P	<u>Nose Bleeds</u>	Y	N	P
				<u>Headache</u>	Y	N	P	<u>Loss of Smell</u>	Y	N	P
				<u>Migraine</u>	Y	N	P	<u>Sinus Infection</u>	Y	N	P
				<u>Tension Headache</u>	Y	N	P	<u>Postnasal Drip</u>	Y	N	P
				<u>Head Injury</u>	Y	N	P	<u>Bad Breath</u>	Y	N	P
				<u>Concussion</u>	Y	N	P	<u>Sore throat</u>	Y	N	P
				<u>Jaw/TMJ Problems</u>	Y	N	P	<u>Odor in Nose</u>	Y	N	P

Review of Systems

Dry/Productive (circle)	Y	N	P
Cough			
Sputum	Y	N	P
Spitting up Blood	Y	N	P
Wheezing	Y	N	P
Asthma	Y	N	P
Allergies	Y	N	P
Bronchitis	Y	N	P
Pneumonia	Y	N	P
Pleurisy	Y	N	P
Emphysema	Y	N	P
Pain on Breathing	Y	N	P
Shortness of Breath	Y	N	P
Positive TB Test	Y	N	P
Heart Disease	Y	N	P
Angina	Y	N	P
High Blood Pressure	Y	N	P
Low Blood Pressure	Y	N	P
Murmurs	Y	N	P
Irregular Pulse	Y	N	P
Blood Clots	Y	N	P
Chest Pain	Y	N	P
Phlebitis	Y	N	P
Palpitations/Fluttering	Y	N	P
Rheumatic Fever	Y	N	P
Swelling in Knees/ Ankles/Feet (circle)	Y	N	P
Stroke	Y	N	P
Valve Prolapse	Y	N	P
Easy Bleeding/Bruising	Y	N	P
Anemia	Y	N	P
Deep Leg Pain	Y	N	P
Varicose Veins	Y	N	P
Thrombophlebitis	Y	N	P
Anal Spasm	Y	N	P
Anal Fissures	Y	N	P
Trouble Swallowing	Y	N	P
Dry Mouth	Y	N	P
Heartburn	Y	N	P
Change in Thirst	Y	N	P
Change in Appetite	Y	N	P
Nausea	Y	N	P
Vomiting	Y	N	P
Blood in Stool	Y	N	P
Mucus in Stool	Y	N	P

Constipation	Y	N	P
Diarrhea	Y	N	P
Black Stools	Y	N	P
Pain or Cramps	Y	N	P
Gallbladder Disease	Y	N	P
Belching	Y	N	P
Gas	Y	N	P
Bloating	Y	N	P
Ulcer	Y	N	P
Jaundice (yellow skin)	Y	N	P
Hemorrhoids	Y	N	P
Liver Disease	Y	N	P
Food Intolerance			
Lactose	Y	N	P
Gluten	Y	N	P
Corn	Y	N	P
Eggs	Y	N	P
Fatty Food	Y	N	P
Yeast	Y	N	P
Pain on Urination	Y	N	P
Burning on Urination	Y	N	P
Increased Frequency	Y	N	P
Increased Urgency	Y	N	P
Frequent Urination at Night	Y	N	P
Incontinence	Y	N	P
Bedwetting	Y	N	P
Hesitancy	Y	N	P
Frequent Infection	Y	N	P
Kidney Disease	Y	N	P
Kidney Stones	Y	N	P
Blood in Urine	Y	N	P
Bladder Pressure	Y	N	P
Urine Odor	Y	N	P
Urethra Pain	Y	N	P
Irritation	Y	N	P
Itching	Y	N	P
Sexually Transmitted Disease	Y	N	P

MALE			
Urination Difficulty	Y	N	P
Swelling or lumps on testicles	Y	N	P
Testicular Pain	Y	N	P
Other:			

FEMALE			
Age at Menarche:			
Date of last menses:			
Abnormal Vaginal Discharge	Y	N	P
Vaginal Odor	Y	N	P
Vaginal Itching	Y	N	P
Vaginal Pain	Y	N	P
Endometriosis	Y	N	P
Fibroids	Y	N	P
Ovarian Cysts	Y	N	P
Sexually Active	Y	N	P
Pain During Intercourse	Y	N	P
Regular Cycles	Y	N	P
Bleeding Between Cycles	Y	N	P
Painful Menses	Y	N	P
Clots	Y	N	P
Abnormal Pap	Y	N	P
Number of Pregnancies			
Number of Miscarriages			
Number of Abortions			
Difficulty Conceiving	Y	N	P
Breast Lumps	Y	N	P
Breast Cysts	Y	N	P
Breast Pain/Tenderness	Y	N	P
Nipple Discharge	Y	N	P
Muscle Spasm	Y	N	P
Joint Pain	Y	N	P
Joint Stiffness	Y	N	P
Joint Deformity	Y	N	P
Joint Redness	Y	N	P
Arthritis	Y	N	P
Broken Bones	Y	N	P
Muscle Weakness	Y	N	P
Muscle Cramps	Y	N	P
Muscle Pain	Y	N	P
Muscle Stiffness	Y	N	P
Back Pain	Y	N	P
Tendonitis	Y	N	P

Additional Concerns: