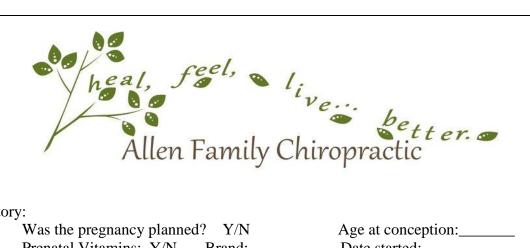
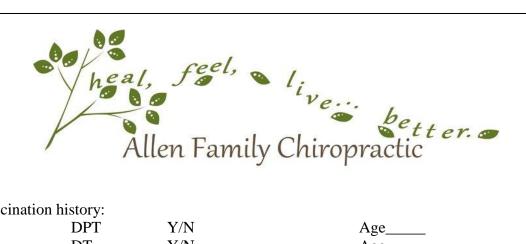


Pediatric Intake Form			Date:_	/	/
Child's Name		Date of Birth	/	/	Sex
Address			•		
City	State_	Zip_			
Grade in school:	_ School:				
Mom's name		Occ	upatio	n	
Phone number					
Dad's name	Occ	Occupation			
Phone number			_		
Parents are: married s	eparated	divorced living tog	gether	other	•
nsurance company					
Name of Insured					
DOB	/	SS#:			
Patier	t relationsh	nip to insured:			
Policy #		Group #			
Ins. Co. Address:					
City	State	ZipPh	one:		
Who should we contact in cas					
Name		Relationship			
Phone Number					
City		_ State Zip_			
Pediatrician's name and locati					
Γop 3 Reasons for visit					
•					
3.					
J				•	
Has your child been seen by a	ny other do	octor(s) for these reason	15?		
Please list any hospitalization					
Touse list any nospitanzation.	o, sui gerres	and dates when they of	Curreu	•	
Dlagge list all medicines 0		your abild is talving (		d/over 4	- <b>h</b> a car
Please list all medicines & sup	ppiements y	your child is taking (pre	escribe	u/over 1	me cour



History:						
Was the pregnan	Was the pregnancy planned? Y/N		Age at conception:			_
Prenatal Vitamin	s: Y/N	Brand:	Dat	e started:		_
Health during pro	egnancy:					
Diabetes	Y/N	1			taken	Y/N
	Y/N	Smoking	Y/N	Recreationa	_	
Nausea	Y/N	Vomiting	Y/N	Emotional S	Stress	Y/N
		Birthing Cent				
Position during I	_abor: E	Back Semi-Si	t l	Fours Position	Squa	tting
		ral Ptosin Episi abor: ho		Forceps Vacuu	ım C-Se	ection
		ght				
Does your child have an	y of the fo	•	s? Is the	re a family histo		
(C=Current, P=Pa						
				Age Age		
				Age		
Colic	1 OX			Age		
				Age		
				Age		
			A	Age		
Eczema_			A	Age		
Finicky E	Eating			Age		
			A	Age		
				Age		
Tantrums	3		A	Age		
Learning impedi	ments					
Speech impedim	ents					-
Known Allergies to food	d, medicin	es, pollens, dander	r, perfum	nes etc:		



Vaccination history:			
DPT	Y/N	Age	
DT	Y/N	Age	
Hepatitis	Y/N	Age	
Tetanus Only	Y/N	Age	
H. Inf. (HiB)		Age	
Polio	Y/N	Age	
MMR	Y/N	Age	
Chicken Pox	Y/N	Age	
Please list any reaction	ons to the vacci	nes	
		Cardiovascular Disease	
Cancer			
Diabetes		Mental Illness	
		es)	
Lunch			
Snack			
Name of the insured			
I understand and agree that health/accimyself. I understand and agree that all payment. I understand that if I suspend me will be immediately due and payab	services rendered to or terminate my calle.	o me and charged are my personal re- re/treatment, any fees for professional	sponsibility for timely
Patient's signature			Date
Spouse's or guardian's signatur	e		Date