



Pediatric Intake Form

Date: ___/___/___

Child's Name _____ Date of Birth ___ / ___ / ___ Sex ___

Address _____

City _____ State _____ Zip _____

Grade in school: _____ School: _____

Mom's name _____ Occupation _____

Phone number _____

Dad's name _____ Occupation _____

Phone number _____

Parents are: married separated divorced living together other

Insurance company _____

Name of Insured _____

DOB ___/___/___ SS#: _____

Patient relationship to insured: _____

Policy # _____ Group # _____

Ins. Co. Address: _____

City _____ State _____ Zip _____ Phone: _____

Who should we contact in case of emergency?

Name _____ Relationship _____

Phone Number _____

Address _____

City _____ State _____ Zip _____

Pediatrician's name and location _____

Top 3 Reasons for visit

1. _____

2. _____

3. _____

Has your child been seen by any other doctor(s) for these reasons? _____

Please list any hospitalizations/surgeries and dates when they occurred:

Please list all medicines & supplements your child is taking (prescribed/over the counter):



History:

Was the pregnancy planned? Y/N Age at conception: _____

Prenatal Vitamins: Y/N Brand: _____ Date started: _____

Health during pregnancy:

Diabetes	Y/N	Preeclampsia	Y/N	Medication taken	Y/N
Caffeine	Y/N	Smoking	Y/N	Recreational drugs	Y/N
Nausea	Y/N	Vomiting	Y/N	Emotional Stress	Y/N

Birth Location: Hospital Birthing Center Home

Name of Obstetrician/Midwife: _____

Position during Labor: Back Semi-Sit Fours Position Squatting

Intervention: None Epidural Ptosin Episiotomy Forceps Vacuum C-Section

Length of Labor: _____ hours

Neonatal Health: Weight _____ Inches _____

How long was your child breast fed? _____ Difficulty latching? Y/N

How many hours does your child sleep during the night? _____

Does your child have any of the following conditions? Is there a family history?

(C=Current, P=Past, M=Mother, F=Father, B=Brother, S=Sister)

Asthma _____	Age _____
Bladder Infection _____	Age _____
Chicken Pox _____	Age _____
Colic _____	Age _____
Constipation _____	Age _____
Diarrhea _____	Age _____
Ear Infection _____	Age _____
Eczema _____	Age _____
Finicky Eating _____	Age _____
Rashes _____	Age _____
Strep Throat _____	Age _____
Tantrums _____	Age _____

Learning impediments _____

Speech impediments _____

Known Allergies to food, medicines, pollens, dander, perfumes etc:



Vaccination history:

DPT	Y/N	Age _____
DT	Y/N	Age _____
Hepatitis	Y/N	Age _____
Tetanus Only	Y/N	Age _____
H. Inf. (HiB)	Y/N	Age _____
Polio	Y/N	Age _____
MMR	Y/N	Age _____
Chicken Pox	Y/N	Age _____

Please list any reactions to the vaccines _____

Family Medical History (C=Current, P=Past, M=Mother, F=Father, B=Brother, S=Sister)

Allergies _____	Cardiovascular Disease _____
Cancer _____	Obesity _____
Diabetes _____	Mental Illness _____

Typical Day's Diet (please include beverages)

Breakfast _____

 Snack _____

 Lunch _____

 Snack _____

 Dinner _____

 Snack _____

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____