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CHILD INTAKE

PERSONAL INFORMATION - *PLEASE PRINT CLEARLY*

PATIENT'S NAME:______________________________ TODAY'S DATE: ______________

PATIENT'S DOB: M______D_______Y_______ PATIENT'S AGE: ______

PARENT/GUARDIAN	PARENT/GUARDIAN
NAME:________________________	NAME:________________________
EMAIL:________________________	EMAIL:________________________
ADDRESS________________________ *STREET*	ADDRESS________________________ *STREET*
________________________ *CITY* *ZIP*	________________________ *CITY* *ZIP*
BEST PHONE # ____________ hm❑ off❑ cell ❑	BEST PHONE # ____________ hm❑ off❑ cell ❑
Voicemail OK? Y❑ N❑	Voicemail OK? Y❑ N❑
OCCUPATION (previous if retired) ____________	OCCUPATION (previous if retired) ____________
EMPLOYER________________________	EMPLOYER________________________

HOW DID YOU HEAR ABOUT US? Please specify: ________________________________

PLEASE LIST YOUR CHILD'S HEALTH CONCERNS (if any):

1. ______________________________
2. ______________________________
4. ______________________________
5. ______________________________

MEDICAL HISTORY - Please check any of the following that apply and note when they started

______	AIDS/HIV Infection	______	Frequent Antibiotic Use	______	Measles
______	Allergies	______	Frequent High Fevers (>102°F)	______	Mononucleosis
______	Anemia	______	Frequent Steroid Use	______	Mumps
______	Appendicitis	______	Genetic Disorder	______	Neurological Disorder
______	Arthritis	______	German Measles	______	Poor concentration
______	Asthma	______	Hayfever	______	Psoriasis
______	Awkwardness	______	Headaches	______	Restlessness
______	Birth Defects	______	Heart Murmur	______	Rheumatic Fever
______	Bladder/Urinary Tract Infections	______	Hepatitis	______	Scarlet Fever/Scarlatina
______	Cancer	______	Herpes/Cold Sores	______	Seizure Disorder
______	Chickenpox	______	Hypoglycemia	______	Social immaturity
______	Chronic Ear Infections	______	Impulsiveness	______	Talkativeness
______	Colitis/Crohn's Disease	______	Inactivity	______	Tantrums
______	Depression	______	Inconsistency	______	Thumb Sucking
______	Developmental Delay	______	Irritability		Until what age? ______
______	Diabetes	______	Jaundice	______	Tuberculosis (TB)
______	Distractibility	______	Kidney Infections	______	Tubes in ears
______	Eating Disorder	______	Left/Right Confusion	______	Whooping Cough
______	Eczema	______	Listlessness		
______	Exposure to Toxic Substances	______	Lyme Disease		

Other: ____

Review of Systems
Please indicate the following N= a condition you have NOW P= a condition you have had in the PAST

Skin
Dry ________
Oily ________
Itching ________
Rashes ________
Hives ________
Fungal Infections ________
Bruises Easily ________
Slow Healing ________
Warts _____ Moles_____
Where ________________________
How Many ________
Nails Soft_____ Break_____

Head
Migraines_____ Headaches_____
Location of pain________________
Worse: Light __ Noise__ Odors__
Head Injury ________
Describe________________________
Dizziness ________
Fainting ________
Seizures ________

Eyes
Vision Disturbance ________
Dryness_____ Tearing_____
Pain ________
Styes ________
Infections ________
Sensitive to Light ________

Ears
Discharge ________
Pain_____ Itch_____
Tubes inserted ________
Impaired Hearing ________
Ringing ________

Nose
Seasonal Allergies ________
Drainage ________
Color: Clear___ Yellow___ Green___
Texture: Runny_____ Thick_____
Post Nasal Drip ________
Stuffiness ________
Sneezing ________
Sinus Infections ________
Nosebleeds ________

Throat/Neck
Pain in Throat ________
Glands Enlarged ________
Difficult Swallowing ________
Change in Voice ________
Clears Throat Often ________

Mouth
Dryness___ Excessive Salivation___
Tongue: Sore___ Coated___
Canker Sores ________

Respiratory
Pneumonia ________
Bronchitis ________
Cough ________
Spit up Blood ________
Asthma ____ Wheezing_____
Shortness of Breath ________
Positive TB Test Ever ________

Cardiovascular
Heart Palpitations/Racing ________
Heart Defect ________
Murmur ________
High___ Low___ Blood Pressure
Leg Pains ____ Cramps____
Ankle Swelling ________
Cold Hands_____ Feet_____

Digestion
Bowel Movement ________
X per day: 1-2___ 2-3___ 3-4___ or
X per week: 1-2___ 2-3___ 3-4___
Texture: Dry___ Hard___
Wet/Loose___ Pellets___
Stools with Mucous___ Blood____
Hemorrhoids
Bleeding___ Painful___ Itching___
Fissures/Fistulas ________
Stool Incontinence ________
Very dark stools ________
Very light stools ________
Bowel Disease ________
Liver/Gallbladder Disease ________
Ulcer ________
Heartburn ________
Bloating ________
Belching ________
Gas / Flatus ________
Nausea / Vomiting ________
Pains / Cramps ________

Urinary
Difficult Urination ________
Painful Urination ________
Incontinence/Dribbling ________
Blood in Urine ________
Frequent Urination Day ________
Night ________
Frequent Bladder Infections ________
Bedwetting ________

Muscular/Skeletal
Back Pain ________
Pain in Muscles/Joints/Bones ________
Stiffness/Swelling ________
Muscle Weakness/Tremor ________
Numbness/Tingling ________
Shooting Pain ________
Paralysis ________
Any Side Worse: R___ L___
Ever Broken Bones?
Which________________________
Ever Sprained Joints?
Which________________________

GENERAL
Energy (scale of 1-10)
1=worst 10=best ________
Best Time of day___ Worst Time ___
Sleep
Good____ Bad____
Wake Easily? Y / N
Why?________________________
Frequently?
Difficulty Falling Asleep Y / N
Wake Refreshed Y / N
Snore Y / N Talk Y / N
Grind Teeth Y / N Sleep Walk Y / N
Preferred Sleeping Position_________
Nightmares Y / N

Temperature
Sensitive to: Hot__ Cold__ Both___
Prefer: Inside___ Outside___
Warm blooded___ Cold blooded___
Best Season___ Worst Season___

Perspiration
Sweat Easily Y / N
Sweat Excessively Y / N
Sweat Very Little Y / N

Appetite
Excessive____ Good____ Poor____
Foods child craves strongly_________
____
Foods child dislikes strongly________
____
Prefers foods Hot__ Warm__ Cold__
Thirst: Excessive __ Good__ Poor__
Prefer drinks: Very Hot___ Hot___
Warm__ Cold__ Ice cold__
Recent Weight Change Y / N

Pregnancy

Nausea _____
Threatened miscarriage _____
High blood pressure _____
Preeclampsia _____
Back pain _____

Birth

_____
Induction (pitocin) _____
Long or difficult labor or delivery _____
Please explain: ____________________
Prematurity _____
Child late _____
Cord around neck _____
Breech delivery _____
Caesarian section with prior labor _____
Scheduled caesarian _____
Rapid delivery _____
Drugs during labor _____
Please list ______________

Neonatal

Rh incompatibility _____
Jaundice _____
Long time to produce breathing _____
Weight at birth _____
Height at birth _____
Colic _____
Much crying for no reason _____
Failure to thrive _____
Breast fed _____
How long? ______
Difficulties with nursing? _______

Development

Periods of separation from mother _____
If so, when? _____ How long? _______
Difficulties learning to walk _____
Difficulties learning to speak _____

Vaccination

_____
Fully vaccinated _____
Partially vaccinated _____
Please specify ______________________
____
Not vaccinated _____
Any unusual vaccines _____
(e.g. yellow fever, Lyme, smallpox)
Vaccine reaction _____

Past History
Hospitalization(s): ______________________________________
____
____

Serious Illnesses and Injuries: __________________________
____
____

Date of Last Physical___________________________________
Date of Last Blood Tests________________________________

Personal Family History:
Please check the "yes" box next to each condition that applies to the child or one of his/her family members. Please note whether the condition applies to the patient by writing the word "child" in the relation column. If the condition applies to a family member, please write the relationship to her/him in the relation column (e.g. mother, aunt, sister, father)

CONDITION	**YES**	**RELATION**	**PAST (P) / NOW (N)**
Alcoholism/Drug Addiction			
Allergies			
Alzheimer's			
Anemia			
Arthritis			
Asthma			
Cancer			
Type?			
Depression			
Diabetes			
Eczema			
Epilepsy			
Headaches			
Heart Attack			
Heart Disease			
Hepatitis			
High Blood Pressure			
High Cholesterol			
Kidney Disease			
Mental Illness			
Osteoporosis			
Stroke			
Suicide			
Thyroid Disease			
Tuberculosis			
Other			

Please list the names of your child's health care providers: ____

____

____

____

Please describe your child's living situation (e.g. divorced parents with joint custody) and any tension at home ____________________

____

Please list all prescription and over the counter medications that s/he is currently taking:

Medication	**Dose**	**Date Started**	**Prescribed By**

List vitamins, minerals, herbs, homeopathic remedies that s/he is currently taking:

Supplement	**Dose**	**Date Started**

Please list any severe or life-threatening allergies that your child has: ________________________________

____

Please Explain____

Personal Habits

	hours/week (present)	**hours/week (past)**
Television		
Computer/Video Games		
Video/Movies		

	how much?	**how long for?**
Soda		
Sweets/Candy		
Coffee/Tea		

Does the child have any dietary restrictions or follow a particular dietary regimen? If yes, please describe:

____

____

Does s/he exercise regularly? Yes No

What type? ____