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PEDIATRIC INTAKE FORM (10+ YEARS)

Patient Name ______________________ Age __________ Date of birth __________

Parent/Guardian name: ______________________

What brings you into the office today? ______________________

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What are your top health concerns, for the above named child, in order of importance? ______________________

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General state of health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of last physical: __________ Date of last dental exam, if applicable: __________

Current mediations (including supplements, vitamins, and herbs): ______________________

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Allergies (drugs, food, chemicals, etc.): ______________________

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Past operations or serious illnesses: ______________________

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MEDICAL HISTORY: (Please check)

☐ Chicken pox	☐ Measles	☐ Mumps	☐ Rubella	☐ Scarlet fever
☐ Strep throat	☐ Pneumonia	☐ Colic	☐ Croup	☐ Bronchitis
☐ Tonsillitis	☐ Ear infection	☐ Allergies	☐ Asthma	☐ Other __________

IMMUNIZATION HISTORY: ☐ Fully vaccinated ☐ No vaccines

FAMILY HISTORY: (Please note health issues/diseases of each family member)

Father: ______________________

Mother: ______________________

Paternal grandfather: ______________________

Maternal grandfather: ______________________

Paternal grandmother: ______________________

Maternal grandmother: ______________________

Siblings: ______________________

FOOD ALLERGIES/SENSITIVITIES: ______________________

____

Describe child's typical daily diet:

Breakfast: ______________________

Lunch: ______________________

Dinner: ______________________

Snacks: ______________________

SLEEP SCHEDULE:

Goes to bed at: __________ Asleep by: __________ Awakes: __________ Awakes rested: __________

Any problems getting to/ staying asleep? ______________________

Is there any history of repeated illnesses? ☐ Yes ☐ No

If yes, what illnesses? ______________________

Are there any concerns regarding growth? ☐ Yes ☐ No

Are there any concerns for learning disabilities? ☐ Yes ☐ No

What concerns? ______________________

Please list any other concerns/health information here: ______________________

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