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PEDIATRIC INTAKE FORM (4-10 YEARS)

Patient Name _____ Age _____ Date of birth _____

Parent/Guardian name: _____

What brings you into the office today? _____

_____

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

_____

_____

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): _____

_____

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

_____

Past operations or serious illnesses: _____

_____

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

If not fully vaccinated, please check which vaccines they have received:

☐ Diptheria Tetanus Pertussis (Dtap)	☐ Flu shot	☐ MMR	☐ Polio
☐ Hepatitis B	☐ Rotavirus	☐ Varicella	☐ Hepatitis A
☐ Pneumoccocal	☐ H. Flu	☐ None	

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: _____

Drinks: _____

Does your child appear to be growing well? ☐ Yes ☐ No

Are there any concerns of developmental delays? ☐ Yes ☐ No

What concerns? _____

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

What concerns? _____

_____

Does your child enjoy school? ☐ Yes ☐ No Why not? _____

_____

Does your child interact well with other children? ☐ Yes ☐ No