Pediatric/Adolescent Health History Intake Form

Last Name: _____ First Name: _____ Today's Date: _____
Preferred Name: _____Date of Birth: _____ Age: _____
Sex at birth: _____ SSN: _____ Child's phone Numbe: _____
Address: _____
Primary Phone number: _____ OK to leave message _____YES_____ NO
Secondary phone number: _____ OK to leave message ____YES_____ NO
Email address: _____ OK to leave Detailed Message ___ YES ____ NO
Emergency Contact: _____ Phone number: _____
Insurance Company: _____ ID Number: _____
Insured Name: _____ Date of Birth _____

Prenatal History

A. **Mother's Pregnancy: □Normal □Complications: _____**
B. **Gestation: _____ weeks**
C. **Birth Location: □Hospital □Birthing Center □Home □Other_____**
D. **Were: _____**
E. **Delivery: □Vaginal □C-Section □Induced**
F. **Complications_____ YES _____NO _____**
G. **Birth Weight: _____lbs. _____ oz. Length: _____ inches**

PRESENT HEALTH CONCERNS Please list most important health concerns in their order of significance

1. _____
2. _____
3. _____
4. _____

Please bring copy of Official record of child's vaccination history for our records

IMMUNIZATIONS

Please place an X next to each vaccination that your child has received.

	Hepatitis A		Measles
	Hepatitis B		Mumps
	Diphtheria		Rubella
	Pertussis		Varicella (Chicken Pox)
	Tetanus		Influenza
	Haemophilus Influenza Type B		Rotovirus
	Polio		Human Papilloma Virus (HPV)
	Pneumococcal		

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MEDICATIONS

Please list all medication + over the counter medications that your child is taking with dosages.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

SUPPLEMENTS: Please list vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

ALLERGIES: Please include mild to severe or life-threatening allergies and reaction (symptoms)

1. **Medication:** _____
2. **Environmental:** _____
3. **Food:** _____

PAST MEDICAL HISTORY

CHILDHOOD ILLNESSES: (Circle and indicate age of illness OR mark C for current as it applies to your child)

Acne:	No	Yes/Age	Ear Infections:	No	Yes/Age
ADD:	No	Yes/Age	Eating Disorders:	No	Yes/Age
ADHD:	No	Yes/Age	Eczema:	No	Yes/Age
Alcohol use:	No	Yes/Age	Headaches:	No	Yes/Age
Allergies:	No	Yes/Age	Head lice:	No	Yes/Age
Asthma:	No	Yes/Age	Mononucleosis:	No	Yes/Age
Bedwetting:	No	Yes/Age	Obesity/Overweight:	No	Yes/Age
Behavior issues:	No	Yes/Age	Pink eye:	No	Yes/Age
Bronchitis:	No	Yes/Age	Pneumonia:	No	Yes/Age
Colic:	No	Yes/Age	Colds:	No	Yes/Age
Constipation:	No	Yes/Age	Sinus Infection:	No	Yes/Age
Cough:	No	Yes/Age	Thrush:	No	Yes/Age
Croup:	No	Yes/Age	Vomiting:	No	Yes/Age
Depression/Anxiety:	No	Yes/Age	Whooping cough:	No	Yes/Age
Diaper Rash:	No	Yes/Age	Other Illness:		Age
Diarrhea	No	Yes/Age	Other Illness:		Age
Drug Abuse	No	Yes/Age			

Please comment on any illnesses indicated above:

_____
_____
_____
_____

PAST MEDICAL HISTORY

HOSPITALIZATIONS

Reason for Hospitalization	Date
_____	_____
_____	_____
_____	_____

SURGERIES

_____	_____
_____	_____
_____	_____

LABS AND EXAM HISTORY

Date of last well child check: _____
Date of last blood work: _____
Date of last urine test: _____
Date of last EKG: _____

SOCIAL HISTORY

Parent's Marital Status: □ Single □ Married □ Divorced □ Separated/Not Divorced □ Widowed □ Domestic Partnership

Are there any family disputes/issues we should be aware of at this time? ____Yes ____No

Living With: □ Both Parents □ Mother □ Father □ StepMother □ StepFather □ Grandparents □ Foster Family □ Other _____

Siblings (Indicate names and year of birth)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Mother's Occupation: _____
Father's Occupation: _____
Guardian's Occupation: _____
Daycare Location: _____
Days/Hours per week attending daycare: _____

SOCIAL HISTORY

NUTRITIONAL HISTORY:

Infant/Toddlers:

Type: □Nursing □Formula/Specify _____ □Both
Duration: □<15 min □15-30 min □ 30-45 min □45-60 min
Frequency: □ Every Hour □ Every other Hour □ Every 3 hours □ Every 4 hours □ Every 5 hours
Amount of formula per feeding: □ <1oz □ 1-2 oz □ 2-3 oz □ 3-4 oz □ >4oz
Have you started solids yet? If so what type _____
How much juice does your infant/toddler drink in a day _____ water _____
What type of milk does your child drink _____ How much per day _____

School Agers/Adolescents:

What is a typical breakfast_____
What is a typical lunch_____
What is a typical dinner _____
What are typical snacks _____
How many glasses of water do you drink each day _____
Do you have any special dietary restrictions _____
TV/Computer: How much time daily (outside of homework) do you spend watching TV/computer screen?
_____
EXERCISE: Do you exercise regularly? ___Yes ___No What type/activity_____
How long _____How Often_____
SLEEP: How many hours of sleep do you get at night on average? _____
Do you have trouble falling asleep? ___Yes ___No Explain: _____
How often do you wake up in the middle of the night and for what reasons_____
_____
Do you have trouble waking up? ___Yes ___No Explain: _____
Do you feel rested when you wake up? ____Yes ____No Explain: _____

ENERGY AND STRESS:

Adolescents: How would you rate your energy on a scale of 1 – 10 with 10 being the most energy? _____
How would you rate your stress on a scale of 1 – 10 with 10 being the most stress? _____
How do you cope with stress? _____
Bullying: Are you bullied? ____ Yes ____No. Do You Bully Others ____Yes ____No

TRAVEL HISTORY: Identify any domestic or foreign travel and indicate year of travel:

Place: _____Year _____
Place: _____Year_____

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Family History

Please PLACE a "C" For current or "P" for past in the box next to each condition that applies to your family members. For Grandparent, mark MM for maternal grandmother, MF for maternal grandfather, PM for paternal grandmother, and PF for paternal grandfather. Mark "A" for Alive and "D for Deceased

	Mother	Father	Sibling	Grandparent	Other
Alcoholism					
Allergies					
Anemia					
Anxiety/ Depression					
Asthma or COPD					
Cancer					
Diabetes					
Drug Addiction					
Eczema					
Epilepsy					
Headaches					
Heart Disease incl. Hypertension or heart attack					
Hepatitis					
Kidney Disease					
Mental Illness					
Stroke					
Thyroid					
Other:					