This is a confidential record of your medical history and will be kept in this office.
The information it contains will not be released to any person without your authorization.

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PEDIATRIC INTAKE FORM (Ages 0 – 18)

Child's Name: ______________________________ Date of Birth:______________ Age: _______

Mother's Name: __________________ Cell: __________________ Occupation: __________________

Father's Name: __________________ Cell: __________________ Occupation__________________

Phone (Home): ______________________Email:____

Address:____

City: ______________________________ State: ______________ Postal Code______________

Emergency contact: ______________________ Phone: ____________ Relation:________________

Who is filling out this form?

____

With whom does the child live? ______________________________ # of siblings: ______________

Has your child ever had a massage and/or acupuncture treatment before? Yes ☐ No ☐

If yes, where and when?

____

Other health care professionals the child is seeing (ie. *Medical Doctor, Pediatrician, Chiropractor, other*)

Name: __________________________ Phone: ____________________Specialty:______________

Name: __________________________ Phone: ____________________Specialty: ______________

Name: __________________________ Phone: ____________________Specialty:______________

How where you referred?

____

Health Concerns

Please list your child's health concerns in order of importance:

____

____

____

____

Signature (person filling out this form): ______________________________ Date: ______________

Name of Child:____

Medical History

Was your child adopted? yes ☐ no ☐ If yes, at what age? _______ What country? ______________________________

List any injuries and/or major surgery your child has had and when they happened:

Has your child ever experienced any of the following?

☐ Rubella
☐ Mumps
☐ Measles
☐ Chickenpox
☐ Whooping cough
☐ Scarlet Fever
☐ Polio
☐ Rheumatic fever

☐ Diaper Rash
☐ Cradle cap
☐ Diarrhea
☐ Constipation
☐ High fevers How many? ______________________________
☐ Bedwetting How often? ______________________________
☐ Strep throat
☐ Frequent colds

☐ Stomach aches
☐ Headaches
☐ Heat or cold intolerance
☐ Ear infections: ________________________
☐ Other illnesses/disease: ________________________

Vaccinations

☐ DPT (Diptheria, Pertusis, Tetanus)
☐ MMR (Measles, Mumps, Rubella)
☐ Chickenpox
☐ Polio

☐ Flu shot
☐ Hepatitis A
☐ Hepatitis
☐ Other: ____________________

Did your child experience any adverse effects from vaccinations? If yes, please explain:

Medications and Supplements

Is your child **currently** taking any medications or supplements (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)? Please list.

Does your child have any medical allergies or sensitivities? Please list.

Signature (person filling out this form): ______________________________ Date: __________________

Name of Child:____

Family History

Please mark if any close relative had any of the following health concern(s).

	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Allergies								
Diabetes								
High Blood Pressure								
Stroke								
Heart Disease								
Seizure								
Cancer								
Hepatitis								
Kidney Disorder								
Thyroid Disorder								
Emotional Disorder								
System Lupus								
Autoimmune Disorder What Kind?								

Prenatal Health and History

	Health at Conception	Health throughout Pregnancy	Age at time of Child's Birth	# of previous pregnancies
Mother	Poor Fair Good Excellent	Poor Fair Good Excellent		
Father	Poor Fair Good Excellent	Poor Fair Good Excellent		

Did the mother experience any food cravings/aversions during pregnancy? Yes ☐ No ☐ If yes, please list:____________________

____

Did the mother receive medical care during pregnancy? Yes ☐ No ☐ Unknown ☐

Did the mother experience any of the following during pregnancy?

☐ Bleeding ☐ Nausea ☐ Physical/Emotional trauma

☐ Vomiting ☐ Thyroid problems ☐ Other: ____________________________

☐ High Blood Pressure ☐ Diabetes

Where any of the following interventions used during pregnancy?

☐ Ultrasound ☐ Chorionic villi sampling ☐ Triple screen

☐ Amniocentesis ☐ Maternal serum screening ☐ Other: ____________________________

Did the mother use any of the following during pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational drugs:______________________

☐ Prescription medications:____

☐ Over-the-counter medications:____

☐ Vitamins or and/or supplements:____

Signature (person filling out this form): ______________________________ Date:____________________

Name of Child:____

Health and Development

At what age did your child first: Sit up ________ Crawl ________ Walk ________ Talk ________

At what age did your child begin teething? ________

Where there any difficulties associated with teething? ____________________

Has your child experienced any pubertal changes? ____________________

Nutritional History

How is/was your infant fed? ☐ Breast fed ☐ Formula: Mild/Soy/Other: ____________________

For how long? ____________________

Did your infant experience any reactions to the breast mild or formula? Yes ☐ No ☐

If yes, please explain:

____

What foods were introduced **before 6 months**? Please list the approximate month and any reactions.

____

____

____

Has your child ever experience colic? Yes ☐ No ☐

If yes, how severely? ☐ Mild ☐Moderate ☐ Severe

At what age and for how long?____________________

Does your child have any food allergies or intolerances? Please list.

____

____

Does your child have any dietary restrictions (vegetarian/vegan, religious, etc.)? ____________________

Does your child have any aversions to any foods? ____________________

Does your child have any environmental allergies or sensitivities? Please list.

____

____

Sleep Patterns

What time does your child usually go to bed?____________________ Wake in the morning?____________________

Does your child nap during the day? Yes ☐ No ☐ What time(s)?____________________

Does your child have nightmares? Yes ☐ No ☐ How often? ____________________

Does your child have any problems associated with sleeping(e.g. trouble falling asleep, grinding teeth, sleep walking, etc.)?____________________

Social Patterns

Is your child in: ☐ school ☐ daycare ☐ homecare ☐ other:____________________

What grade level? ____________

Signature (person filling out this form): ____________________ Date: ____________________

Name of Child:____

How would you describe your child's behavior at school? ____

____

____

How would you describe your child's behavior at home? ____

____

____

Does your child make friends easily? Yes ☐ No ☐

What are your child's interest & favorite activities? ____

____

Is your child physically active regularly? Yes ☐ No ☐ How much & how often? ______________________________

____

Does your child have any habits (e.g. thumb sucking)? ____

____

Does your child have any
fears?____

Approximately how much television does your child watch?_______________________________ hours/day.
Does your child play on the computer or video games? Yes ☐ No ☐ If yes, ________________ hours/week.
How often does your child read (not for school) or How often does someone read to your child?
☐ Daily ☐ Several times a weeK ☐ Weekly ☐ Less than weekly

Environment

Are there any pets in the home? Yes ☐ No ☐ What type and how many? ______________________
Does anyone in the child's household smoke? Yes ☐ No ☐
How is the child's home
heated?____

Do you use humidifiers in your home? Yes ☐ No ☐
How would you describe the emotional climate of the child's home? ____________________________________

____

____

Has your child ever had any significant physical or emotional traumas?_________________________________

____

____

Signature (person filling out this form): ______________________________ Date: ________________