Health Intake Form

Pediatric

Today's Date: _____

Client Name: _____

Date of birth: _____ Age: _____ Biological Sex: Male Female

Address: _____

Parents or Guardians Name: Mother: _____ Father: _____

Social History: Parents: Married Divorced Separated

Siblings: _____

Phone: Home: _____ Cell: _____

Parents or Guardian Email: _____

Person to notify in case of emergency: _____ Relationship: _____

Cell: _____

Who can we thank for referring you? _____

Has any other family member already been a patient at the clinic? Y or N

What goals do you have for your visit today?

- _____
- _____

What are your major health concerns in order of importance?

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

How did these conditions develop? Are there traumatic events, medications, etc that you can identify as having caused or clearly aggravated your health problems. What happened in your life around this time?

_____

Current Medications (list all prescriptions with dosages):

1. _____ 3 _____
2. _____ 4 _____

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Current Therapies:

_____

Natural Supplements:

1. _____ 3 _____

2. _____ 4 _____

What other health care practitioners are you currently seeing?

1. _____ 2. _____

Are you allergic to any drugs, foods, chemicals, animals, environmental substances? Y or N

What/what happens?_____

Describe your child's disposition:

_____

Significant Life Events:

- Major traumas, emotional loss, accidents:

  _____

- Hospitalizations:

  _____

- Surgeries:

  _____

- Dental issues or trauma:

  _____

- Antibiotic History:

  _____

Prenatal, Perinatal & Birth:

Any health issues, Lyme disease, major stress events, or complications?

_____

C section? Y or N Umbilical Cord issues? Y or N Antibiotics? Y or N

Breast Fed? Y or N Formula fed? Y or N Did you have colic? Y or N

Age Solid foods started: _____

What foods do you grow up on? _____

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What significant childhood illnesses have you had?

- Rashes/cradle cap: Y or N Constipation: Y or N Colic: Y or N
- Mononucleosis: Y or N Strep Throat: Y or N Asthma: Y or N
- Scarlet Fever: Y or N Ear Infections: Y or N Adenoids/Tonsil Issues: Y or N
- Whooping Cough: Y or N Thrush: Y or N Mood or Learning Disorder: Y or N
- Lyme Disease: Y or N

Significant Family/Genetic History: *Has any Blood Relative had any of the following: Heart Disease, Cancer, Diabetes, Kidney disease, Autoimmune Disease, or Lyme Disease?*

Child's Siblings: _____

Mother: _____

Father: _____

Grandparents: _____

Immunization History:

- Following Standard schedule? Y or N Have not received any vaccines? Y or N
- Covid, Flu, RSV history: _____
- Any adverse reactions, immediately to 1 week after immunization? Y or N
    - If Yes, please explain symptoms: _____

Diet and Lifestyle:

Mold or water damaged building at home or school? Y or N

How much water (in ounces) do you drink daily? _____

List any foods you crave? _____

Do you react to any foods? Y or N What Foods and reactions?_____

Typical meal options:

- Breakfast: _____
- Lunch: _____
- Dinner: _____

SLEEP:

Do you have trouble falling asleep? Y or N

Do you wake at night and can't fall back to sleep? Y or N