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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 medications (including supplements, vitamins, and herbs): _____

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

Past operations or serious illnesses: _____

MEDICAL HISTORY: (Please check)

- | | | | | |
|---------------------------------------|--|------------------------------------|----------------------------------|--|
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Rubella | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Strep throat | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Colic | <input type="checkbox"/> Croup | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Ear infection | <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other _____ |

IMMUNIZATION HISTORY: Fully vaccinated No vaccines

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

- | | | | |
|--|------------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Diphtheria Tetanus Pertussis (Dtap) | <input type="checkbox"/> Flu shot | <input type="checkbox"/> MMR | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Rotavirus | <input type="checkbox"/> Varicella | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Pneumococcal | <input type="checkbox"/> H. Flu | <input type="checkbox"/> 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