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Pediatric Intake

Client Name: _____ Birth Date:_____

Address: _____

Telephone:_____ Email:_____

Mother's/Father's Name: _____

Mother's/Father's Name: _____

Siblings:

Name:_____ Age:_____ Gender:_____

Name:_____ Age:_____ Gender:_____

Name:_____ Age:_____ Gender:_____

Name:_____ Age:_____ Gender:_____

Name:_____ Age:_____ Gender:_____

Referred By:

Family Medical History

Please indicate if any blood relatives to the child have had any of the following by using the notations:

M = Mother
F = Father
S = Sibling
MGM = Maternal Grandmother
MGF = Maternal Grandfather
_____ PGM = Paternal Grandmother
_____ PGF = Paternal Grandfather

___ Allergy, Asthma or Eczema
___ Cancer
___ Diabetes or Low Blood Sugar
___ Heart Trouble
___ High Blood Pressure/Stroke
___ Kidney Disease
___ Liver Disease
___ Developmental Disability
___ Mental Illness
___ Scoliosis
___ Ulcer
___ Seizure Disorder
___ Vaccine Reaction
___ Other: _____

Pregnancy

Please check any areas that applied to the client's mother during her pregnancy:

- ○ Prenatal Classes
- ○ Ultrasounds
- ○ Premature Contractions
- ○ Complications
- ○ Back Pain
- ○ Bleeding
- ○ Other Pain
- ○ Hospitalization
- ○ Smoking
- ○ Alcohol
- ○ Recreational Drugs
- ○ Excessive Weight Loss
- ○ Excessive Weight Gain
- ○ Medications
- ○ Toxic Exposures
- ○ Caffeine: Cola
- ○ Caffeine: Coffee
- ○ Caffeine: Tea
- ○ Caffeine: Chocolate
- ○ Caffeine: Other
- ○ Immunizations/Flu Shot
- ○ Allergic Reactions
- ○ Mental Trauma
- ○ Vitamins/Minerals
- ○ Chiropractic Care
- ○ Any Diagnosed Illnesses
- ○ Attitude – Mostly Happy
- ○ Attitude – Mostly Depressed
- ○ Physical Injury

Labor & Delivery

Please check any items(s) that apply:

- ○ Home Birth
- ○ Hospital Birth
- ○ Induction
- ○ Caesarean
- ○ Complications
- ○ Fetal Monitor Used
- ○ Premature Delivery
- ○ Medications
- ○ Vacuum Extraction
- ○ Forceps
- ○ Other: _____

Please check any item(s) that applied to the client at birth:

- ○ Difficulty Breathing
- ○ Choking
- ○ Crying
- ○ Sleeping Excessively
- ○ Difficulty Waking/Lethargic
- ○ Jaundice
- ○ Coloring
- ○ Difficulty latching on
- ○ Difficulty breastfeeding
- ○ Medications
- ○ Surgery
- ○ Circumcision
- ○ Formula Feeding
- ○ Vitamin K
- ○ Erythromycin
- ○ Other: _____

Nutrition

Please indicate if the client has received any of the following:

- ○ Breast Milk
- ○ Commercial Formula
- ○ Cow's Milk
- ○ Goat's Milk
- ○ Other Milk: _____
- ○ Juice: Fruit
- ○ Juice Vegetable
- ○ Solid Foods
- ○ Vegetarian Diet
- ○ Organic Meats
- ○ Vitamins
- ○ Sweets/Candy
- ○ Medications
- ○ Other: _____

Illnesses

Please list any illnesses or previously diagnosed conditions:

Health Care Providers

Pediatrician:

Chiropractor:

Homeopath:

Occupational Therapist:

Other:

General System Review

Please check any that apply to client:

- Had any allergies, eczema, hay fever, hives, asthma or drug reactions?
- Been unconscious or had a convulsion?
- Had problems with the eyes, including vision?
- Been cyanotic (turned blue)?
- Had recurring problems with vomiting, diarrhea, constipation or stomach pain?
- Had problems passing stools?
- Had unusual stools in appearance or smell?
- Had problems passing urine?
- Had unusual urine in appearance or smell?
- Complain of any extremity or back pain?
- Do you notice a limp or unusual gait pattern?
- Tolerated exercise?
- Had any other problems?