PEDIATRIC INTAKE FORM
(6-12 years old)
Kristin Stiles Green, NMD

Name _____ Date _____

Age _____ Date of Birth _____ female _____ male_____

Mother's name_____ Father's name _____

Address _____

Phone #'s (home) _____(cell) _____

Email addresses_____

Is there anyone we can thank for referring you here? _____

Name of Doctor's office/Clinic where your child's, former health records are kept:

_____

What are your child's most important health problems?
List in order of importance, please.

1)_____

2)_____

3)_____

4)_____

Does your child have a contagious disease at this time? Y N

If yes, what? _____

Previous Illnesses

Rheumatic fever	Y N	German measles	Y N
Chicken pox	Y N	Measles	Y N
Tonsillitis	Y N	approx. number _____	
Ear infection	Y N	approx. number _____	

Other? Please list _____

Has your child had any of the following tests? When & where?

Electroencephalogram (EEG) _____

Psychological evaluations _____

Hearing tests _____

Speech/Language tests _____

Hospitalizations/ Surgeries/ Injuries

What hospitalizations, surgeries or injuries has your child had?

_____

_____

Immunizations

What immunizations has your child had; Is she/he current on his/her immunization schedule? _____

_____

Any adverse reactions? Y or N If yes, what were they? _____

Allergies

Is your child hypersensitive or allergic to?

Any drugs?_____

Any foods? _____

Any environmental things?_____

Breast fed? Y or N How long? _____ Formula? Y or N What type? _____

Typical Food Intake

Breakfast:_____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Please list ALL prescription medications, over-the-counter medications, vitamins, herbs, homeopathics or other supplements your child is taking, regularly. Please note ingredients, milligram amounts and frequency.

_____

_____

_____

_____

REVIEW OF SYSTEMS FOR YOUR CHILD

Y = a condition now, **P** = a condition in the past, **N** = never had

MENTAL/ EMOTIONAL

Mood Swings	Y	P	N	Anxiety/nervousness	Y	P	N
Irritability	Y	P	N	Cries easily	Y	P	N
Hyperactivity	Y	P	N	Unusual fears	Y	P	N
Introvert/extrovert	Y	P	N	Sleep problems	Y	P	N
Motion/car sickness	Y	P	N	Nightmares	Y	P	N

ENDOCRINE

Heat/cold intolerance	Y	P	N	Fatigue	Y	P	N
Excessive thirst	Y	P	N	Excessive hunger	Y	P	N
Low blood sugar	Y	P	N	High blood sugar	Y	P	N

SKIN

Rashes	Y	P	N	Eczema, Hives	Y	P	N
Acne, Boils	Y	P	N	Itching	Y	P	N

HEAD

Headaches	Y	P	N	Head Injury	Y	P	N
Dizzy spells	Y	P	N	High fevers	Y	P	N

EYES

Glasses or contacts	Y	P	N	Tearing or dryness	Y	P	N
Eye pain/strain	Y	P	N				

EARS

Earaches	Y	P	N	Impaired hearing	Y	P	N

NOSE AND SINUSES

Frequent colds	Y	P	N	Nose Bleeds	Y	P	N
Stuffiness	Y	P	N	Hay fever	Y	P	N
Sinus problems	Y	P	N	Loss of smell	Y	P	N

MOUTH AND THROAT

Frequent sore throat	Y	P	N	Canker sores	Y	P	N
Breath odor	Y	P	N				

RESPIRATORY

Cough	Y	P	N	Wheezing	Y	P	N
Asthma	Y	P	N	Bronchitis	Y	P	N

CARDIOVASCULAR

Heart disease	Y	P	N	Murmurs	Y	P	N

URINARY

Frequent urination	Y	P	N	Bed wetting	Y	P	N

GASTROINTESTINAL

Belching/passing gas	Y	P	N	Stomachaches	Y	P	N
Constipation	Y	P	N	Diarrhea	Y	P	N

Bowel Movements : How often _____

MUSCULOSKELETAL

Joint pain/stiffness	Y	P	N	Muscle spasms/cramps	Y	P	N
Broken bones	Y	P	N				

BLOOD/PERIPHERAL VASCULAR

Anemia	Y	P	N	Easy bleeding/bruising	Y	P	N

Is there any information about your child's health that you would like to add?

_____

_____

_____

_____

_____

Welcome! We are glad to be of service to you and your child