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:
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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 If N

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?

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____

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.

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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?

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