

Pediatric Intake Form

Name of child (printed): _____ Age: _____ Child DOB: _____

Name of parent/guardian filling out form (printed): _____ Relationship to child _____

Today's date _____

Describe the problem(s) for which you are seeing the physician today: _____

Which side of the body is injured/hurting? (circle one) **RIGHT LEFT N/A Body part** _____

Is the problem getting: Better Same Worse (please explain) _____

How did the problem begin? _____

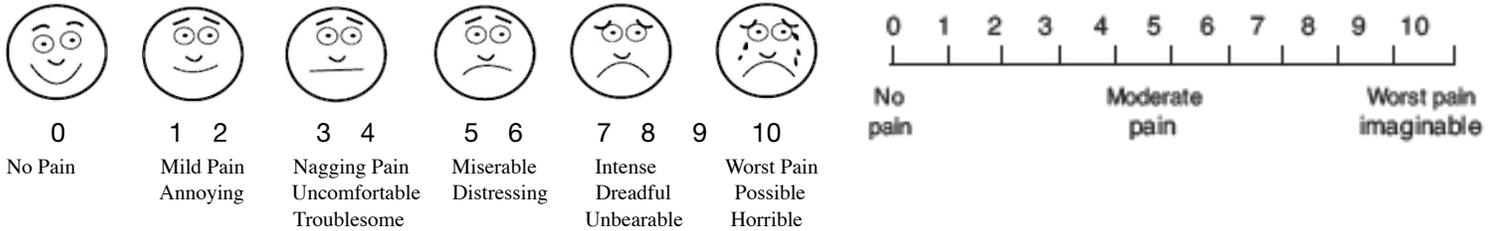
When did the problem begin? _____

What makes the problem better? _____

What makes the problem worse? _____

Is there pain? **Yes No** (If no, skip next 2 questions)

For the next 2 questions: (younger patients: parents please refer to the faces below, older patients please rate you pain on a scale of 0-10)



What was the level of pain when it first started: 0 1 2 3 4 5 6 7 8 9 10

And what is the level of pain now: 0 1 2 3 4 5 6 7 8 9 10

Have you seen any other physicians/clinicians for this problem? (If yes, please explain)

Have you taken any medications for the pain? (If yes, please list)

For this problem, please list any studies ordered:

- X-rays: area of body _____ date _____ location _____
- CT Scan: area of body _____ date _____ location _____
- MRI Scan: area of body _____ date _____ location _____
- Blood work: date _____ location _____
- Bone Scan: area of body _____ date _____ location _____

Patient Medical History -	Yes	No	Comments	Yes	No	Comments
<i>Does your child have:</i>						
1. Congenital heart defects and/or murmurs						12. Rheumatoid arthritis
2. Seizures						13. Prematurity
3. Congenital anomalies						14. History of special education
4. Meningitis						15. Thyroid problems
5. BPD (bronchopulmonary dysplasia)						16. Scoliosis/spinal problems
6. Neurologic deficits						17. Neuromuscular disorders (Cerebral Palsy/spina bifida/other muscle or bone disorders)
7. ROP (retinopathy of prematurity)						18. Learning disorders (ADHD, dyslexia, etc.)
8. Down Syndrome						19. Sleep Apnea/Snoring/Pneumonia
9. Asthma/other						20. Gastric reflux/GERD
10. Cancer/blood disorders/anemia						
11. Diabetes						

Allergy History:

Drug allergies: None Known Yes (Please list your child's allergies and the reaction) _____

Latex Allergies: Yes No (If yes, what is the reaction) _____

Medications:

List any medications you are currently taking (prescription, over the counter, and vitamins): _____

Past Surgeries: Please list all surgeries and what year surgery was performed): _____

Prior Hospitalizations: Yes No (If yes, what was the reason for the hospitalization and what year): _____

Family History: <i>Has anyone in your immediate family ever been treated for any of the following:</i>	Yes	No	Relative	Current Health <i>Have you noticed any of the following symptoms in your child or does your child complain of:</i>	Yes	No	Comments
1. Diabetes				1. Constitutional: Unexplained weight loss/gain, fever, chills, sweats, fatigue			
2. Heart disease				2. Eyes: Glasses/contacts, blurred/double vision			
3. High blood pressure				3. ENT: Ringing in ears/hearing problems			
4. Cancer				4. CV: chest pain/heart palpitations			
5. Osteoporosis or metabolic bone disease				5. Respiratory: shortness of breath/cough/wheezing			
6. Rheumatoid arthritis/Lupus/ other inflammatory disorders				6. GI: nausea/vomiting/heartburn			
7. Mental illness				7. GU: bowel/urinary problems			
8. Bleeding disorders				8. Mskl: Joint/bone pain			
9. Neurologic disorders/Migraines				9. Neurologic: numbness/tingling/dizziness/balance problems			
10. Asthma/Reactive Airway disease				10. Psychiatric: Depression/anxiety/nervousness			
11. Unexplained sudden death				11. Hematologic: Easy bleeding/bruising			
12. Alcohol/drug dependency				12. Skin: Skin problems			
Social History				13. Other _____			

Social History

School _____

Grade _____

Performance in school (circle one):

Above Average Average Below Average

What sports/activities does the patient participate in? None (or specify below) _____

Do you exercise regularly? Yes No (If yes, how many hours per week): _____

Which best describes the patient's living arrangements? (check all that apply)

Lives with both biological parents

Lives with one parent/guardian (circle one) (mother, father, grandparent, other)

• Specify who is the legal guardian (mother, father, other) _____

Lives with adoptive parents

Other (please explain) _____

Please indicate parent(s)/guardian(s) occupation: _____

Does the patient smoke? **YES NO** (circle one)

Do any other members in the household smoke? **YES NO** (circle one)

Do you or your child have a need to discuss any emotional or physical harm that you or your child may be experiencing?

Do you ever feel unsafe at home or has anyone hit your child or tried to injure your child?

Patient Signature or Parent/Legal Guardian _____ Date: _____ Time: _____

Reviewed by: _____ Date: _____ Time: _____