Alpine Valley Wellness Center, PC

Pediatric Intake Form

Our practice is dedicated to providing the best possible care for your child. In order for us to serve you better, please take a few minutes to answer the following questions. Your answers will be kept strictly confidential.

Child's Name__________________________________ **Age**______ **Birth Date**_____________ **Sex: M/F**

Caregiver's Name_____________________________________ **Social Security #**_______________________

Caregiver's Home Phone__________________ **Work Phone** _________________ **Cell Phone**______________

Are you the child's: ❑ Birth Parent ❑ Foster parent ❑ Grandparent ❑ Other relative ❑ Other
Besides you, does anyone else take care of the child? ❑ Yes ❑ No If yes, who? _________________________
Has child received health care elsewhere? ❑Yes ❑No If yes, where? _________________________________
Does the child have any allergies to any medications? ❑ Yes ❑ No If yes, what? _______________________
Has the child received any immunizations? ❑ Yes ❑ No If yes, where? ______________________________
Which ones? ____
Has the child ever been hospitalized? ❑ Yes ❑ No If yes, when? ____________________________________
Where? ________________________________ Why? ____
Any history of head injury? ❑ Yes ❑ No If yes, when? ____
Has this child ever been unconscious? ❑ Yes ❑ No If yes, why? ___________________________________
How would you rate this child's health in general? ❑. Excellent ❑. Good ❑. Fair ❑ Poor
Do you have any concerns about your child's behavior or development? ❑ Yes ❑ No
If yes, what? ____
Reason for visit to the doctor:____
____
Duration of complaints/symptoms:____
What has been done so far?____
____
Current medications and their doses:____
____

What pets live with you-indoors or/and outdoors____
____
When and where have you traveled outside the country? ____
____
____
What is your religion and how important is religion/spirituality in your family's life?
_________________________________ ____

Early childhood illnesses :
First illness at _________ months First antibiotic at ________ months

Number of ear infections in the first 2 years: ______________________________________

Number of other infections in the first 2 years: ________ Which ones?______________________________

How many times on antibiotics in the first 2 years?_______ Which ones?______________________________

PREGNANCY HISTORY OF PATIENT:

Duration of pregnancy: ________________ Birth Weight:______ Total weight gained in pregnancy:_________
Any complications during pregnancy?____
Any drugs taken during pregnancy? (include over-the-counter medications): ____________________________
Any alcohol?___________ How much?____
Any tobacco?___________ How much?____
High blood pressure?____
Illnesses/Infections during pregnancy?____

Difficulty getting pregnant (>6mo) ❑ Yes ❑ No Infertility drugs used ❑ Yes ❑ No
In vitro fertilization ❑ Yes ❑ No Drink alcohol ❑ Yes ❑ No Smoke tobacco ❑ Yes ❑ No
Take progesterone ❑ Yes ❑ No NOT Take prenatal vitamins ❑ Yes ❑ No
Take antibiotics ❑ Yes ❑ No Take other drugs ❑ Yes ❑ No If yes, which?_________________
Have a viral infection ❑ Yes ❑ No Have a yeast infection ❑ Yes ❑ No
Amalgam fillings put in teeth ❑ Yes ❑ No Have any amalgams removed from teeth ❑ Yes ❑ No
Have bleeding ❑ Yes ❑ No If yes, which months?___________ Group B strep infection ❑ Yes ❑ No
Have an x-ray ❑ Yes ❑ No Have Rhogam ❑ Yes ❑ No If yes, how many? ______________
High blood pressure ❑ Yes ❑ No Have house exterminated ❑ Yes ❑ No
Have house painted ❑ Yes ❑ No Chemical exposure ❑ Yes ❑ No

LABOR AND DELIVERY:

How long was labor? _____________ Breech or unusual presentation?________________________
Cesarean Birth? ❑ Yes ❑ No If yes, why?____
Pain medication used? ❑ Yes ❑ No If yes, which?____
Pitocin used? ❑ Yes ❑ No Forceps used? ❑ Yes ❑ No Delay in respiration or cry? ❑ Yes ❑ No
Was oxygen administration necessary? ❑ Yes ❑ No Apgar Score, if known?___________________

NEWBORN:

Jaundice? ❑ Yes ❑ No Cyanosis? ❑ Yes ❑ No Infection? ❑ Yes ❑ No Anemia? ❑ Yes ❑ No
Other important medical conditions: ____

Your Child's Medical History

Please circle or fill in where indicated if your child has ever had any of the following :

AIDS/HIV +
Allergies______________________
Anemia
Asthma
Back pain
Bladder/urinary problems
Cancer________________________
Cerebral palsy
Chest pain
Chickenpox
Colitis/irritable bowel
Diabetes ❑ Type I
Ear or hearing problems
Epilepsy
Eye problems

Fatigue, chronic
Frequent antibiotic use
Gall bladder/ Liver problems
Gastrointestinal problems_________
Gum/teeth problems
Hair loss
Hayfever
Headaches/Migraines
Heart problems_________________
Hepatitis ❑ A ❑ B ❑ C ❑ Other
Hypoglycemia
Jaundice
Joint problems
Kidney/ Urinary problems
Measles

Mental Health Issues___________________
Mononucleosis / Epstein Barr virus
Movement Disorders____________________
Mumps
Neurological conditions___________________
Parasites ____________________________
Rheumatic fever
Seizures
Sexual abuse
Sinusitis
Skin problems/rashes___________________
Stroke
Tuberculosis
Thyroid problems
Other _______________________________