Family Centered
HEALTHCARE, P.A.

Pediatric Intake Form

Today's Date: _______________

Child's Name: ___________________________ Date of Birth: ______________________

Parent's Name (s): _______________________ _________________________

Past History:

1. What was the child's birth weight? ______________
2. How far along (how many weeks gestation) was the mother of the patient when she delivered? ______________
3. Were they any significant issues or medical problems that occurred during pregnancy? ☐ Yes ☐ No
   List any issues:
   ____
   ____
   ____
4. Were there any significant issues/medical problems that occurred during labor and/or the delivery?
   ☐ Yes ☐ No
   If yes, what were those issues:
   ____
   ____
   ____
   ____
5. Has the patient been diagnosed with any medical problems? ☐ Yes ☐ No
   What are these problems?
   ____
6. What medications, supplements, or vitamins is the patient taking?
   ____
7. Has the patient had any surgeries? ☐ Yes ☐ No
   If so, which surgeries:
   ____
8. List any concerns that there have been about your child's growth and/or development?
   ____
   ____
   ____
   ____

Family History:

1. What illnesses does the father of the patient have?
   ____
2. What illnesses does the mother of the patient have?
   ____
3. What illnesses does the patient's siblings have?
   ____
4. What illnesses does the patient's other family members have?
   ____

Social History:

1. Does the patient have any exposure to cigarettes or other tobacco products? This includes family members that only smoke outside: ☐ Yes ☐ No
   If so, who smokes in the family: ____
2. Does the child: ☐ Stays at home with family Who? ______________________________
   ☐ Go to daycare Name/Location: ______________________________
   ☐ Go to school Name/Location: ______________________________
3. List the type of pets you have in the home:
   ____
4. **Diet:**
   Check all that apply: ☐ Breastfeeding ☐ Bottle (Breast milk) ☐ Bottle (formula) ☐ Solid food
   ☐ City Water ☐ Well Water
   ☐ Milk (circle all that apply): Cows Goats Almond Soy Rice Other: _______

   Is it fortified with Vitamin D? __________
   Describe the child's eating frequency and amount:
   ____
   ____
   ____
   ____
5. What is your family's plan regarding current/future vaccinations?
   - ☐ Religious exemption/ No vaccines
   - ☐ Follow the CDC guidelines
   - ☐ Delayed schedule
   - ☐ Unsure at this time/ Want to discuss

Please give any details you believe will be helpful in determining your wishes regarding vaccinations, or concerns/questions you may have:

____
____
____
____
____

6. Please note any questions or concerns you have that you would like to discuss with your provider:

____
____
____
____
____