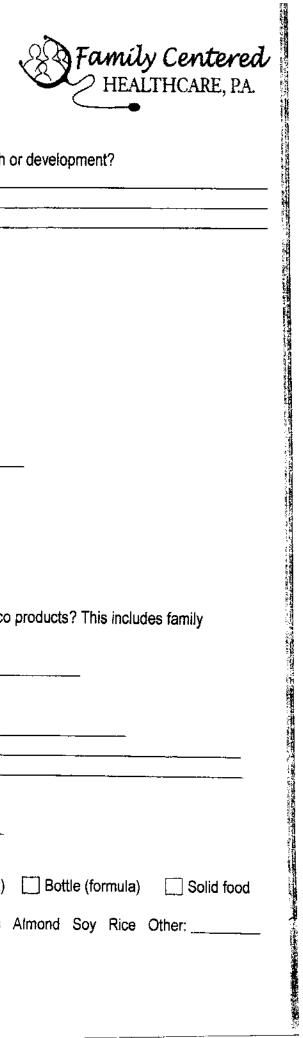


Pediatric Intake Form

TODA	Y'S DATE:
CHILD	D'S NAME: DOB:
PARE	NT'S NAMES:
<u>PAST</u>	HISTORY
1.	What was the patient's child's birth weight?
2.	How far along (how many weeks gestation) was the mother of the patient when she delivered?
3.	Were there any significant issues or medical problems that occurred during pregnancy? No / YES List those issues:
4.	Were there any significant issues / medical problems that occurred during labor and the delivery? NO / YES. If yes, what were those issues:
5.	Has the patient been diagnosed with any medical problems? NO / YES What are these problems?
6.	What medications, supplements, or vitamins is the patient taking?
7.	Has the patient had any surgeries? NO / YES If so, which surgeries:



8.	List any concerns that there have been about your child's growth or development?
<u>Famil</u>	LY HISTORY
1.	What illnesses does the father of the patient have?
2.	What illnesses does the mother of the patient have?
3.	What illnesses do the patient's siblings have?
4.	What illnesses do the patient's other family members have?
	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? in daycareName/Location: In schoolName/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 Weil Water Milk (circle all that apply): Cows Goats Almond Soy Rice Other:
	Is it fortified with Vitamin D?



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١	What is your family's plan regarding current / future vaccinations?
	Religious exemption / No vaccines
_	c. Delayed schedule
	d. Unsure at this time / Want to discuss
<u>-</u>	
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