



1 Hollow Lane, Suite 30 • Lake Success, NY 11042 • (516) 365-5395

*This is a confidential record of your medical history and will be kept in this office.
The information it contains will not be released to any person without your authorization.*

PEDIATRIC INTAKE FORM (Ages 0 – 12)

Child's Name: _____ Date of Birth: _____ Age: _____

Mother's Name: _____ Cell: _____ Occupation: _____

Father's Name: _____ Cell: _____ Occupation: _____

Phone (Home): _____ Email: _____

Address: _____

City: _____ State: _____ Postal Code: _____

Emergency contact: _____ Phone: _____ Relation: _____

Who is filling out this form? _____

With whom does the child live? _____ # of siblings: _____

Has your child ever had a massage and/or acupuncture treatment before? Yes No

If yes, where and when? _____

Other health care professionals the child is seeing (ie. *Medical Doctor, Pediatrician, Chiropractor, other*)

Name: _____ Phone: _____ Specialty: _____

Name: _____ Phone: _____ Specialty: _____

Name: _____ Phone: _____ Specialty: _____

How were you referred? _____

Health Concerns

Please list your child's health concerns in order of importance:

Signature (person filling out this form): _____ Date: _____

Name of Child: _____

Medical History

Was your child adopted? yes no If yes, at what age? _____ What country? _____

List any injuries and/or major surgery your child has had and when they happened:

Has your child ever experienced any of the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Diaper Rash | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Cradle cap | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Heat or cold intolerance |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Constipation | <input type="checkbox"/> Ear infections: |
| <input type="checkbox"/> Whooping cough | <input type="checkbox"/> High fevers | How many? _____ |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Bedwetting | How often? _____ |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Strep throat | <input type="checkbox"/> Other illnesses/diseases: |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Frequent colds | _____ |

Vaccinations

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> DPT (Diphtheria, Pertusis, Tetanus) | <input type="checkbox"/> Flu shot |
| <input type="checkbox"/> MMR (Measles, Mumps, Rubella) | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Other: _____ |

Did your child experience any adverse effects from vaccinations? If yes, please explain:

Medications and Supplements

Is your child **currently** taking any medications or supplements (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)? Please list.

Does your child have any medical allergies or sensitivities? Please list.

Name of Child: _____

Family History

Please **mark** if any close relative had any of the following health concern(s).

| | Mother | Father | Brother | Sister | Maternal grandmother | Maternal grandfather | Paternal grandmother | Paternal grandfather |
|---------------------|--------|--------|---------|--------|----------------------|----------------------|----------------------|----------------------|
| Allergies | | | | | | | | |
| Diabetes | | | | | | | | |
| High Blood Pressure | | | | | | | | |
| Stroke | | | | | | | | |
| Heart Disease | | | | | | | | |
| Cancer | | | | | | | | |
| Seizure | | | | | | | | |
| Hepatitis | | | | | | | | |
| Kidney Disorder | | | | | | | | |
| Thyroid Disorder | | | | | | | | |
| Emotional Disorder | | | | | | | | |
| Systemic Lupus | | | | | | | | |

Prenatal Health and History

| | Health at conception | | | | Health throughout pregnancy | | | | Age at time of child's birth | # of previous pregnancies |
|--------|----------------------|------|------|-----------|-----------------------------|------|------|-----------|------------------------------|---------------------------|
| Mother | Poor | Fair | Good | Excellent | Poor | Fair | Good | Excellent | | |
| Father | Poor | Fair | Good | Excellent | Poor | Fair | Good | Excellent | | |

Did the mother experience any food cravings/aversions during pregnancy? Yes No If yes, please list: _____

Did the mother receive medical care during pregnancy? Yes No Unknown

Did the mother experience any of the following during pregnancy?

- Bleeding
- Vomiting
- High Blood Pressure
- Nausea
- Thyroid problems
- Diabetes
- Physical/Emotional trauma
- Other: _____

Where any of the following interventions used during pregnancy?

- Ultrasound
- Amniocentesis
- Chorionic villi sampling
- Maternal serum screening
- Triple screen
- Other: _____

Did the mother use any of the following during pregnancy?

- Tobacco
- Prescription medications: _____
- Over-the-counter medications: _____
- Vitamins or and/or supplements: _____
- Alcohol
- Recreational drugs: _____

Signature (person filling out this form): _____

Date: _____

Name of Child: _____

Health and Development

At what age did your child first: Sit up _____ Crawl _____ Walk _____ Talk _____

At what age did your child begin teething? _____

Were there any difficulties associated with teething? _____

Has your child experienced any pubertal changes? _____

Nutritional History

How is/was your infant fed? Breast fed Formula: Mild/Soy/Other: _____

For how long? _____

Did your infant experience any reactions to the breast milk or formula? Yes No

If yes, please explain: _____

What foods were introduced **before 6 months**? Please list the approximate month and any reactions.

Has your child ever experience colic? Yes No

If yes, how severely? Mild Moderate Severe

At what age and for how long? _____

Does your child have any food allergies or intolerances? Please list.

Does your child have any dietary restrictions (vegetarian/vegan, religious, etc.)? _____

Does your child have any aversions to any foods? _____

Does your child have any environmental allergies or sensitivities? Please list.

Sleep Patterns

What time does your child usually go to bed? _____ Wake in the morning? _____

Does your child nap during the day? Yes No What time(s)? _____

Does your child have nightmares? Yes No How often? _____

Does your child have any problems associated with sleeping (e.g. trouble falling asleep, grinding teeth, sleep walking, etc.)? _____

Social Patterns

Is your child in: school daycare homecare other: _____

What grade level? _____

Name of Child: _____

How would you describe your child's behavior at school? _____

How would you describe your child's behavior at home? _____

Does your child make friends easily? Yes No

What are your child's interest & favorite activities? _____

Is your child physically active regularly? Yes No How much & how often? _____

Does your child have any habits (e.g. thumb sucking)? _____

Does your child have any fears? _____

Approximately how much television does your child watch? _____ hours/day.

Does your child play on the computer or video games? Yes No If yes, _____ hours/week.

How often does your child read (not for school) or How often does someone read to your child?

Daily Several times a week Weekly Less than weekly

Environment

Are there any pets in the home? Yes No What type and how many? _____

Does anyone in the child's household smoke? Yes No

How is the child's home heated? _____

Do you use humidifiers in your home? Yes No

How would you describe the emotional climate of the child's home? _____

Has your child ever had any significant physical or emotional traumas? _____

Signature (person filling out this form): _____ Date: _____

THANK YOU

