



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 where 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? _____

Where 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

