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PEDIATRIC INTAKE FORM (6-12 YEARS)

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____ DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CONTACT TELEPHONE # (HOME): _____ (CELL): _____ (WORK): _____

AGE: _____ DATE OF BIRTH: _____ M _____ F _____

PARENT'S NAMES: _____

HOW DID YOU HEAR ABOUT THIS CLINIC? _____

HEALTH HISTORY QUESTIONNAIRE

WHAT ARE YOUR CHILD'S MOST IMPORTANT HEALTH CONCERNS? LIST AS MANY AS YOU CAN IN ORDER OF CONCERN.

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

IS YOUR CHILD SICK AT THIS TIME? Y _____ N _____

WAS YOUR CHILD BREAST FED? Y _____ N _____ FORMULA? Y _____ N _____ KIND? _____

FAMILY HISTORY

DOES YOUR CHILD HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING?

___ CANCER	___ DIABETES	___ HEART DISEASE	___ HIGH BLOOD PRESSURE
___ KIDNEY DISEASE	___ EPILEPSY	___ ARTHRITIS	___ GLAUCOMA
___ TUBERCULOSIS	___ STROKE	___ ANEMIA	___ MENTAL ILLNESS
___ ASTHMA/HAYFEVER/HIVES	___ ALCOHOLISM		

ANY OTHER RELEVANT FAMILY HISTORY? _____

WHAT IS YOUR CHILD'S HERITAGE? _____

CHILDHOOD ILLNESSES

PLEASE CHECK IF YOUR CHILD HAS HAD:

___ SCARLET FEVER ___ DIPHTHERIA ___ RHEUMATIC FEVER ___ CHICKEN POX
___ MUMPS ___ MEASLES ___ GERMAN MEASLES ___ RHEUMATIC FEVER
___ EAR INFECTIONS ___ STREP THROAT ___ ANTIBIOTICS (# OF TIMES ___) ___ OTHER

ANY MAJOR INJURIES? _____

HEARING/SPEECH/LANGUAGE TESTS? _____

IMMUNIZATIONS

___ POLIO ___ PERTUSSIS ___ MEASLES/MUMPS/RUBELLA
___ TETANUS ___ DIPHTHERIA OTHERS _____

ANY ADVERSE REACTIONS? Y___ N___ IF SO, EXPLAIN? _____

HOSPITALIZATIONS, SURGERY, IMAGING

WHAT HOSPITALIZATIONS, SURGERIES, X-RAYS, CAT SCANS, EEGs, EKGs, ULTRASOUNDS, HAS YOUR CHILD HAD?

_____ YEAR: _____ _____ YEAR: _____
_____ YEAR: _____ _____ YEAR: _____
_____ YEAR: _____ _____ YEAR: _____

ALLERGIES

ANY DRUGS? _____

ANY FOODS? _____

ANY CHEMICALS OR ENVIRONMENTALS? _____

MEDICATIONS

PLEASE LIST ALL PRESCRIPTION MEDICATIONS, OVER THE COUNTER MEDICATIONS, VITAMINS, HERBAL MEDICINES, AND SUPPLEMENTS YOUR CHILD TAKES.

- 1) _____ 4) _____
- 2) _____ 5) _____
- 3) _____ 6) _____

GENERAL

HEIGHT: _____ WEIGHT: _____ LBS. WEIGHT ONE YEAR AGO: _____ LBS.

MAXIMUM WEIGHT: _____ LBS. WHEN: _____

WHEN IS YOUR CHILD'S ENERGY THE BEST? _____ WORST? _____

RATE YOUR CHILD'S ENERGY (1-10) _____ IS THIS A CHANGE? _____

HOW IS YOUR CHILD'S MOOD? _____ IS THIS A CHANGE? _____

HOW IS YOUR CHILD'S APPETITE? _____ IS THIS A CHANGE? _____

TYPICAL FOOD INTAKE:

BREAKFAST: _____

LUNCH: _____

DINNER: _____

SNACKS: _____

CRAVINGS: _____

DRINKS: _____

REVIEW OF SYSTEMS

Y=A CONDITION YOU HAVE NOW

P = SIGNIFICANT IN THE PAST

N = NEVER HAD

MENTAL/EMOTIONAL

TREATED FOR EMOTIONAL PROBLEMS?	Y	P	N	DEPRESSION?	Y	P	N
ANXIETY OR NERVOUSNESS?	Y	P	N	MOOD SWINGS?	Y	P	N
CONSIDERED/ATTEMPTED SUICIDE?	Y	P	N	EATING DISORDER?	Y	P	N
TENSION?	Y	P	N	POOR CONCENTRATION?	Y	P	N

ENDOCRINE

THYROID PROBLEMS?	Y	P	N	HEAT OR COLD INTOLERANCE?	Y	P	N
HIGH OR LOW BLOOD SUGAR?	Y	P	N	DIABETES?	Y	P	N
EXCESSIVE THIRST?	Y	P	N	EXCESSIVE HUNGER?	Y	P	N
FATIGUE?	Y	P	N	SEASONAL DEPRESSION?	Y	P	N
CRY EASILY?	Y	P	N	HAIR LOSS?	Y	P	N

IMMUNE

FREQUENT ILLNESSES?	Y	P	N	SWOLLEN GLANDS?	Y	P	N
SLOW WOUND HEALING?	Y	P	N	AUTOIMMUNE DISEASE?	Y	P	N
CANCER?	Y	P	N	WHAT TYPE?			

NEUROLOGIC

SEIZURES?	Y	P	N	DIZZINESS/LIGHTHEADEDNESS?	Y	P	N
LOSS OF BALANCE?	Y	P	N	PARALYSIS?	Y	P	N
NUMBNESS/TINGLING?	Y	P	N	MUSCLE WEAKNESS?	Y	P	N
LOSS OF MEMORY?	Y	P	N	EASILY STRESSED?	Y	P	N

SKIN/HAIR/NAILS

RASHES?	Y	P	N	ECZEMA/HIVES?	Y	P	N
ACNE/BOILS?	Y	P	N	ITCHING?	Y	P	N
DRY/FLAKY SKIN OR BRITTLE NAILS?	Y	P	N	COLOR CHANGES?	Y	P	N
LUMPS?	Y	P	N	NIGHT SWEATS?	Y	P	N

HEAD

HEADACHES?	Y	P	N	MIGRAINES?	Y	P	N
TMJ PROBLEMS?	Y	P	N	HEAD INJURY OR CONCUSSION?	Y	P	N

EYES

BLURRY VISION?	Y	P	N	DOUBLE VISION?	Y	P	N
SPOTS IN THE EYES?	Y	P	N	EYE PAIN/STRAIN?	Y	P	N
COLOR BLINDNESS?	Y	P	N	TEARING OR DRYNESS?			

EARS

IMPAIRED HEARING?	Y	P	N	RINGING?	Y	P	N
DIZZINESS?	Y	P	N	EARACHES?	Y	P	N
EAR INFECTIONS?	Y	P	N	CLICKING NOISE ON SWALLOWING?	Y	P	N

NOSE

LOSS OF SMELL?	Y	P	N	STUFFINESS?	Y	P	N
SINUS PROBLEMS?	Y	P	N	FREQUENT COLDS?	Y	P	N
NOSE BLEEDS?	Y	P	N	HAY FEVER?	Y	P	N

MOUTH AND THROAT

FREQUENT SORE THROAT?	Y	P	N	SORE LIPS/TONGUE?	Y	P	N
COPIOUS SALIVA?	Y	P	N	HOARSENESS?	Y	P	N
CAVITIES?	Y	P	N	GUM PROBLEMS?	Y	P	N
TEETH GRINDING?	Y	P	N	JAW CLICKING?	Y	P	N

NECK

LUMPS?	Y	P	N	GOITER?	Y	P	N
SWOLLEN GLANDS?	Y	P	N	STIFF/PAINFUL NECK?	Y	P	N

CARDIOVASCULAR

CHEST PAIN?	Y	P	N	PALPITATIONS/FLUTTERS?	Y	P	N
MURMUR?	Y	P	N	SWELLING OF ANKLES?	Y	P	N
BLOOD CLOTS?	Y	P	N	CONGENITAL DEFECT?	Y	P	N
FAINING?	Y	P	N	RHEUMATIC FEVER?	Y	P	N

RESPIRATORY

COUGH?	Y	P	N	SPUTUM?	Y	P	N
SPITTING UP BLOOD?	Y	P	N	WHEEZING?	Y	P	N
ASTHMA?	Y	P	N	SHORTNESS OF BREATH?	Y	P	N
PNEUMONIA?	Y	P	N	BRONCHITIS?	Y	P	N
PLEURISY?	Y	P	N	TUBERCULOSIS?	Y	P	N
PAIN ON BREATHING?	Y	P	N	DIFFICULTY BREATHING?	Y	P	N
LIGHTHEADED WITH EXERTION?	Y	P	N	SHALLOW BREATHING?	Y	P	N

GASTROINTESTINAL

DIFFICULTY SWALLOWING?	Y	P	N	HEARTBURN?	Y	P	N
CHANGE IN THIRST?	Y	P	N	CHANGE IN APPETITE?	Y	P	N
ULCER?	Y	P	N	NAUSEA?	Y	P	N
VOMITING?	Y	P	N	VOMITING BLOOD?	Y	P	N
BELCHING OR GAS?	Y	P	N	PAIN OR CRAMPS?	Y	P	N
BOWEL MOVEMENTS: HOW OFTEN _____ IS THIS A CHANGE? Y N				DIARRHEA?	Y	P	N
CONSTIPATION?	Y	P	N	BLOOD IN STOOL?	Y	P	N
BLACK STOOL?	Y	P	N	HEMMORHOIDS?	Y	P	N

URINARY

PAIN ON URINATION?	Y	P	N	INCREASED FREQUENCY?	Y	P	N
FREQUENCY AT NIGHT?	Y	P	N	INABILITY TO HOLD URINE?	Y	P	N
FREQUENT URINARY TRACT INFECTIONS?	Y	P	N	KIDNEY STONES?	Y	P	N
KIDNEY DISEASE?	Y	P	N	ABNORMAL COLOR OR SMELL OF URINE?	Y	P	N

MALE REPRODUCTIVE

HERNIAS?	Y	P	N	TESTICULAR MASSES?	Y	P	N
TESTICULAR PAIN?	Y	P	N	SEXUALLY ACTIVE?	Y	P	N

FEMALE REPRODUCTIVE/BREASTS

AGE OF FIRST MENSES?				AGE OF LAST MENSES?			
IS YOUR CYCLE REGULAR?	Y	P	N	DURATION OF CYCLE (#DAYS)?			
DURATION BETWEEN CYCLES (# DAYS)?				BLEEDING BETWEEN CYCLES?	Y	P	N
PAIN/CRAMPING DURING MENSES?	Y	P	N	HEAVY OR EXCESSIVE FLOW?	Y	P	N
CLOTTING?	Y	P	N	OVARIAN CYSTS?	Y	P	N
FIBROIDS?	Y	P	N	ENDOMETRIOSIS?	Y	P	N
ABNORMAL PAP?	Y	P	N	CERVICAL DYSPLASIA?	Y	P	N
SEXUALLY ACTIVE?	Y	P	N	BIRTH CONTROL METHOD?			
VAGINAL DISCHARGE?	Y	P	N	VAGINAL ITCHING?	Y	P	N
BREAST LUMPS?	Y	P	N	INTERSTITIAL CYSTITIS?	Y	P	N
BREAST PAIN OR TENDERNESS?	Y	P	N	NIPPLE DISCHARGE?	Y	P	N

MUSCULOSKELETAL

JOINT PAIN OR STIFFNESS?	Y	P	N	BROKEN BONES?	Y	P	N
MUSCLE CRAMPS?	Y	P	N	MUSCLE WEAKNESS?	Y	P	N

BLOOD/PERIPHERAL VASCULAR

EASY BLEEDING?	Y	P	N	EASY BRUISING?	Y	P	N
ANEMIA?	Y	P	N	SWELLING?	Y	P	N

IS THERE ANY OTHER INFORMATION ABOUT YOUR CHILD'S HEALTH THAT YOU WOULD LIKE TO ADD?

SIGNATURE: _____ DATE: _____

Thank you for taking time to help me better understand your child's whole health. I look forward to working with you and your child. If you have any questions please ask!

Dr. Holcomb Johnston