



Mountain Spring
HEALTH CLINIC

PEDIATRIC INTAKE 0-12 years old DATE: _____

Full Legal Name: _____ / _____ / _____

Last Name

First Name

Middle Initial

Preferred Name: _____ Age: _____ Date of Birth: _____ Birth Weight: _____

Mother's Name: _____ Father's Name: _____

Address _____ / _____ / _____ / _____

street # / PO Box

city

state

zip code

Telephone: (H) _____ (W) _____ (M) _____

E-mail Address: _____ Gender: Female _____ Male: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Number: (H) _____ (W) _____ (M) _____

How did you hear about our clinic? _____

Has any other family member already been a patient at the clinic? _____

COMMUNICATION

What is the best way to communicate with you between office visits? E-mail / Home ph. / Work ph. / Cell ph.

Is there any place you do NOT want us to leave a message? _____

May our practitioner(s) discuss your private medical information with you via e-mail*? Y N

May we send you educational/promotional materials such as newsletters via e-mail? Y N

NOTE: Please be aware that email is not a secure communication, and that discussion of your medical care will become part of your medical record.

HEALTH HISTORY

What are your child’s most important health concerns? List in order of importance.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____

What has already been done for the above-mentioned concerns? And what results?

Does your child have a contagious disease at this time? Y N If yes, what? _____

MEDICATION & SUPPLEMENTS

Please list all your child’s prescription and over-the-counter medications, homeopathic remedies, herbs, vitamins and minerals, or other supplements, with dosages.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____

BIRTH HISTORY

List major patterns of illness present in the child’s birth mother, father, or their families:

Did mother receive:

prenatal care? Y N prenatal vitamins? Y N medications? Y N Please list: _____

Did mother:

smoke cigarettes? Y N drink alcohol? Y N illicit drugs? Y N Please list: _____

Any difficulties with the pregnancy (nausea, vomiting, bleeding, etc)?

Type of birth (hospital, home, C-section, etc)? _____

Carried to term? Y N If no, how premature? _____

Complications of labor or delivery? _____

PREVIOUS ILLNESSES

Describe difficulties during infancy (colic, ear infections, skin or lung problems, etc):

Has your child had any of the following childhood illnesses?

- Diphtheria Mumps Strep Throat German Measles Rheumatic Fever Measles
 Scarlet Fever Other _____

How often does your child get:

never	occasionally	frequently	constantly	_____	coughs	_____
colds	_____	_____	_____	_____	diarrhea	_____
sore throat	_____	_____	_____	_____	constipation	_____
earaches	_____	_____	_____	_____	tummy aches	_____

Has your child had any of the following?	When?	Where?
electroencephalogram?	_____	_____
psychological evaluation?	_____	_____
hearing tests?	_____	_____
speech/language tests?	_____	_____

What hospitalizations, surgery, or injuries has your child had? Please give dates and reasons:

IMMUNIZATION HISTORY

What immunizations has your child had? *Please circle all that apply*

- Diphtheria Hepatitis B Polio inactive (IPV)
 Diphtheria, Tetanus Hepatitis C oral (OPV)

Diphtheria, Tetanus, Pertussis Influenza (flu shot) Rubella, single

Tetanus, single Measles, single Varicella (chicken pox)

Haemophilus Influenza type b Mumps, single

Hepatitis A Measles, Mumps, Rubella (MMR) Other _____

Are your child's immunizations current? Y N

If not, please explain: _____

Reactions to immunizations? _____

ALLERGIES *Is your child hypersensitive to:*

Any drugs? _____

Any foods? _____

Any environmental? _____

Was/Is your child: Breast-fed? Y N Formula-fed? Y N

Age solid food was introduced? _____

First food introduced (if known)? _____

FOOD & DIET *Please describe your child's typical food intake.*

Breakfast Lunch Dinner Snacks Beverages _____

HEALTH HABITS *Does your child:*

Watch TV? Y N hours / day _____ Read? Y N hours / day _____ Play video games? Y N hours / day _____

Play sports? Y N hours / day _____ What are your child's favorite activities? _____

Day care / School / Home school? (circle) Grade level? _____

Does anyone in your household smoke? Y N

Are there pets in the home? Y N What kind? _____

SOCIAL HISTORY

With whom does your child live? _____ Are parents together / divorced / separated? (circle)

If not together, what if any arrangements are made with the other parent (eg. visitation)?

List age and gender of siblings; indicate half or step-siblings where applicable.

Were any of the mother's pregnancies not carried to term?

ENVIRONMENTAL

What type of dwelling do you live in? _____ How old? _____

Water source? _____ Type of heat? _____

Any difficulties with school? Please describe.

How would you describe your child's personality? _____

Describe any problems in the following areas:

Digestion: _____

Skin: _____

Respiratory: _____

Urinary: _____

How much sleep does your child get? From ____ pm to ____ am. Quality? _____

Was your child early or late in rolling over, teething, or talking? _____

Is there anything not covered in this questionnaire that you would like to let your doctor know?

Thank you for your time and effort. We look forward to providing you with the best possible care