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. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 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. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 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