vitality
WELLNESS CLINIC

New Pediatric Patient Intake

Please fill out as much information as possible. You can either type your responses, save the pdf and then email the completed form to us at **office@vitalitynhc.com**. Or, you can print out the form, write your answers and then bring it with you on your next visit.

Patient Name: ______________________ DOB: ____________

Street Address: ______________________

City: ____________ State: _____ Zip Code: ________ Phone: ____________

Sex: ☐ M / ☐ F Grade of School: _______ Nickname: ____________

Mother's Name: ______________________ Occupation: ____________

Father's Name: ______________________ Occupation: ____________

Parents are: ☐ Married / ☐ Separated Divorced / ☐ Living Together / ☐ Other: ____________

Reason for Office Visit: ______________________

Has child been seen by any other doctor(s) for this complaint? ☐ Y/ ☐ N / ☐ Past

Regular Pediatrician name & phone number: ______________________

Last time any blood work was done and with what physician: ______________________

List ALL Surgeries & Hospitalizations, including date occurred: ______________________

1) ______________________ 3) ______________________

2) ______________________ 4) ______________________

List ALL medicines (from drugstore or prescription) child is currently taking:

1) ______________________ 3) ______________________

2) ______________________ 4) ______________________

List ALL Supplements the child is currently taking:

1) ______________________ 3) ______________________

2) ______________________ 4) ______________________

Any known Allergies to foods, drugs, environment, animals:

____

____

Previous Medical History

YES (Y) indicates the child gets the problem regularly
NO (N) indicates the child never had the problem
PAST (P) indicates the child had the problem in the past, but not recently

Please check the correct answer for your child:

Ear Infections: ☐ Y / ☐ N / ☐ P If has had, how many times? ______________

Colds: ☐ Y / ☐ N / ☐ P If has had, how many times? ______________

Strep Throat: ☐ Y / ☐ N / ☐ P If has had, how many times? ______________

How many times has the child taken antibiotics? ______________________

What other medicines has the child taken and how often? ______________________

1) ______________________ 3) ______________________

2) ______________________ 4) ______________________

Hearing Test Normal:☐ Y /☐ N /☐ Not Tested

Vision Test Normal: ☐ Y / ☐ N / ☐ Not Tested

Speech Impediments: ☐ Y / ☐ N / ☐ Not Tested

Learning Impediments: ☐ Y / ☐ N / ☐ Not Tested

Vaccination History

YES (Y) has had | **NO (N)** has not had | **SOME (S)** did not finish all shots

MMR: ☐ Y / ☐ N / ☐ S
DPT: ☐ Y / ☐ N / ☐ S
Hep B: ☐ Y / ☐ N / ☐ S

Hib: ☐ Y / ☐ N / ☐ S
Chicken Pox: ☐ Y / ☐ N / ☐ S
Polio: ☐ Y / ☐ N / ☐ S

Other: ____

Any reactions to vaccinations? If yes, please explain:

____

____

Family History

Conditions	Father	Mother	Mother's Mom	Mother's Dad	Father's Mom	Father's Dad	Sibling
Allergies:	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Cancer:	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Diabetes:	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
GI Disease:	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Heart Disease:	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Kidney Disease:	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Lung Disease:	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Metal Illness:	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Tuberculosis:	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Vision/Hearing Impaired:	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N

Mother's Pregnancy History

Age at conception: ______________________ Is this the first child? ☐ Y / ☐ N

Due date: ______________________________ When did you start seeing the doctor? ___________

Mother's Health During Pregnancy

During Pregnancy did you:

Have High Blood Pressure? ☐ Y / ☐ N

Have gestational diabetes? ☐ Y / ☐ N

Take any medicines? ☐ Y / ☐ N

Smoke cigarettes? ☐ Y / ☐ N

Drink alcohol? ☐ Y / ☐ N

Use other drugs? ☐ Y / ☐ N

Nausea / Vomiting? ☐ Y / ☐ N

Emotional stress? ☐ Y / ☐ N

Drink coffee? ☐ Y / ☐ N

Was child premature? ☐ Y / ☐ N

Was baby breech? ☐ Y / ☐ N

Was it a cesarean delivery? ☐ Y / ☐ N

If the birth was difficult, please explain:

____

____

What is Mother's blood type? ____________ What is child's blood type? ______________________

Place of Child's birth: ____________________ Name of OB/Midwife/Doula: ____________________

Health of baby at birth: ____

____

Health History of Child

Baby's Birth Weight: __________ Baby's Birth Length: __________ Head Circumference: __________

Did baby breathe / cry immediately? ☐ Y / ☐ N Was baby jaundiced at birth? ☐ Y / ☐ N

Was PKU testing done at birth? ☐ Y / ☐ N Was child breastfed: ☐ Y / ☐ N

If so, for how long? ______________________________

Formula: ☐ Y / ☐ N At what age? ______________ Kind used: ______________

When was child put on solid foods? ______________________________

Any problems/Allergies/Sensitivities: ______________________________

Jaundice As Baby:	☐ Y / ☐ N	Colic:	☐ Y / ☐ N
Cradle Cap:	☐ Y / ☐ N	Anemia:	☐ Y / ☐ N
Eczema or Psoriasis:	☐ Y / ☐ N	Asthma:	☐ Y / ☐ N
Diarrhea:	☐ Y / ☐ N	Warts:	☐ Y / ☐ N
Constipation:	☐ Y / ☐ N	Nightmares:	☐ Y / ☐ N
Finicky Eating:	☐ Y / ☐ N	Bed Wetting:	☐ Y / ☐ N
Poor Teeth:	☐ Y / ☐ N	Tantrums:	☐ Y / ☐ N
Chronic Sniffles:	☐ Y / ☐ N	Disobedient:	☐ Y / ☐ N
Bad Foot Odor:	☐ Y / ☐ N	Fears/Phobias:	☐ Y / ☐ N
Very Sweaty Baby/Child:	☐ Y / ☐ N	Diaper Rash:	☐ Y / ☐ N
Hyperactivity:	☐ Y / ☐ N	Early Puberty:	☐ Y / ☐ N
Growing Pains:	☐ Y / ☐ N	Stomach Aches:	☐ Y / ☐ N

Has the child experienced, witnessed or gone through, any household stressors?

____

____

Social Development History

Mother's age: ______________________ Father's age: ______________________

Child has how many sisters? __________ Brothers? ______________________

Child is the oldest, middle, or youngest in the family? ______________________

Other children's ages: ______________________

Who spends the most time caring for the child? ______________________

Does the child go to daycare/babysitter/preschool on a regular basis? ☐ Y / ☐ N

Are there any pets in the home? ☐ Y / ☐ N How many? __________ Type? __________

Any smokers in the home? ☐ Y / ☐ N

At what age did the child: ☐ Sit up? ☐ Crawl? ☐ Walk? ☐ Start talking?

Concerns / Problems

Does your baby/child have any on-going problem(s) that concern you?

Please check all that apply:

☐ Eats too little ☐ Eats too much ☐ Speaks unclearly

☐ Cries a lot ☐ Has frequent temper tantrums ☐ Wets bed

☐ Difficulty sleeping ☐ Frequently constipated ☐ Small for age

☐ School problems ☐ Behavior problems ☐ Sees poorly

☐ Doesn't always respond to noise / spoken words ☐ Runny noses/cough

Are there any other problems / concerns?

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____

____

____

Typical Day's Diet

Breakfast: ____________________

____

Lunch: ____________________

____

Dinner: ____________________

____

Snacks: ____________________

____

Toxin Exposure

Has the child ever lived near a refinery, polluted area or in a home with leaded paint? If so, what was the child exposed to? ____________________

Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health at all? ____________________

Does the child seem particularly sensitive to perfumes, gasoline or other vapors? ____________

Do you spray pesticides, herbicides or other chemicals around your home? ____________

How did you hear about our office?

____

____________________	____________________	____________
Print Name	**Sign Name**	**Date**