EASTSIDE INTEGRATIVE MEDICAL GROUP

Pediatric Intake Paperwork

Child's Name:______________________________ Date of Birth:______________ M or F
Address____
Phone Numbers:____
Email Address:____
Your Name:________________________________Relationship to Child:________________
Mother's Name:____________________________ Birthdate:_______________
Occupation:_________________________Ht:________ Wt:___________
Father's Name:_____________________________Birthdate:_______________
Occupation:_________________________Ht:________Wt:___________
Names of Living Brothers/Sisters and Birthdates:

Was this child adopted? No ◯ Yes ◯ At what age?______ From where?_______________
Religious Preference?___________________________

Reason for visit:____
Date of last physical exam: / /
Does the child have a primary care physician or other health care providers? No ◯ Yes ◯
If yes, who?____

Pregnancy History:

Number of pregnancies before this one:________
How long was this pregnancy?________________
How many weeks/months pregnant when prenatal care began?___________
Were there any of the following illnesses or problems?
Rubella/Measles ◯ Accident/Injury ◯ Bleeding ◯ High Blood Pressure ◯
Swelling ◯ Sugar in Urine ◯ Excessive Weight Gain ◯
Other Infections ◯ Explanation:____
Medicines/Supplements used during pregnancy?____________________________________
Did you smoke while pregnant? No ◯ Yes ◯ If yes, how often?_____________________
Did you drink alcohol during pregnancy? No ◯ Yes ◯ If yes, how often?______________

Birth Information:

Birthplace:__________________ Home ◯ Hospital ◯ Birth Center ◯
How long was labor? ___________ Was labor induced? No ◯ Yes ◯
At delivery: (check all that apply)
Breech (feet/bottom) ◯ C-section ◯ VBAC ◯
Resuscitated ◯ Needed Oxygen ◯ Breathed/Cried Immediately ◯
Blood Transfusion ◯ Antibiotics ◯ Lights ◯
Did baby have: (check all that apply)
Breathing problems ◯ Jaundice ◯ Other:_____________________
At birth: Weight__________ Height___________ Length_________ Apgar_________
Discharge Weight___________ Length of Hospital Stay __________
Did baby receive: Vitamin K ◯ Hep B Vaccine ◯ Newborn Screening Tests ◯
Describe any problems with birth or the first few days:_________________________________

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Family Background:

Ethnic Origin/Race:

Mother______________________ **Father** _____________________

Parents: Married ◯ Living Together ◯ Separated ◯ Divorced ◯ Single ◯

Child lives with: Both parents ◯ Mother ◯ Father ◯ Guardian ◯

Other members of household:____

Age of home? ___________ **Any pets?** _____________

Has a parent, brother or sister died? No ◯ Yes ◯ If yes, who?_______________________

Cause of death_____________________ **Age at death**___________

Please check the box in which the child's blood relative has had any of the following…	Father	Mother	Fathers Side	Mothers Side	Siblings
Headaches (migraine, tension, etc)					
Eye Disease (blind, tumor, glaucoma)					
Ear Disease (deaf, infection, defects)					
Allergies (eczema, hay fever, etc)					
Lung Disease (asthma, cystic fibrosis)					
Tuberculosis					
High Blood Pressure					
High Cholesterol					
Heart Attack					
Heart Disease					
Anemia					
Bleeding Disorders					
Stomach or Duodenal Ulcers					
Liver or Gallbladder Disease (hepatitis)					
Intestinal Disease (colitis, polyps, etc)					
Kidney Disease (cysts, nephritis, stones)					
Diabetes					
Thyroid Problems					
Bone or Joint Disease (arthritis, osteoporosis)					
Muscle Weakness or Dystrophy					
Seizure Disorder					
Neurologic Disorder					
Learning Disability					
Mental Retardation (Down Syndrome, other)					
Mental Illness (depression, anxiety, other)					
Alcoholism or Drug Abuse					
Birth Defects (cleft lip, etc)					
Obesity					
Cancer (Type:)					

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Infant Nutrition:

◯ **Breastmilk (Duration: ___ weeks/months/years) Avg number of nursing episodes in 24 hours:____**
◯ **Formula (Brand:___________, Ounces/day:________, Age at first use:________)**
◯ **Solid Foods (Age at first use:________)**

Does baby have any trouble with the following?

Vomiting ◯ **Colic** ◯ **Diarrhea** ◯ **Allergies** ◯
Using Pacifier ◯ **Using bottle** ◯ **Starting Solid Foods** ◯

Childhood Nutrition: What has your child eaten in the last day?

Breakfast:____
Lunch:____
Dinner:____
Snacks:____
Fluids:____

What are your child's favorite foods?

Proteins:____
Fruits:____
Vegetables:____
Treats:____

Sleep and Elimination:

Bowel Movements Per Day:__________ Wet Diapers/Urination Per Day:__________
Where/with whom/how does your child sleep?____
Does your child share a room or bed? Do they cosleep? On a bunk bed? On tummy or back?____
What time is typical bedtime?_________ What time do they typically wake?_________
Do they wake up during the night? No ◯ **Yes** ◯ **If yes, how often? _________**
How many naps during the day?________ How long are the naps? __________
Any sleep problems? No ◯ **Yes** ◯ **If yes, ____**

Medical History:

Has your child had any of the following?

Measles/Rubella__________________ Anemia ______________________________
Mumps _________________________ Heart Disease_________________________
Chickenpox______________________ Allergies/Hay Fever_____________________
Whooping Cough_________________ Eczema ________________________________
Scarlet Fever ____________________ Asthma ________________________________
Rheumatic Fever _________________ Pneumonia ____________________________
Convulsions/Seizures______________ Hepatitis_______________________________
Strep Throat_____________________ Ear Infection___________________________
Other Illnesses:____

Has your child ever been injured? No ◯ **Yes** ◯ **If yes, how so and what age?____________________**
Any fractures? No ◯ **Yes** ◯ **If yes, where?_______________**
Has your child lost consciousness or had a concussion? No ◯ **Yes** ◯ **If yes, how?________________**
Has your child had an accidental poisoning? No ◯ **Yes** ◯ **If yes, what and when?________________**
Has your child ever had surgery? No ◯ **Yes** ◯ **If yes, what and when?_________________________**
Has your child ever had a blood transfusion? No ◯ **Yes** ◯ **If yes, why and when?________________**

Has your child ever been hospitalized for any other reason?___________________________________

Has your child ever worn:

- **Glasses** ◯ **Contact Lenses** ◯ **Dental Braces** ◯
- **Leg Braces** ◯ **Corrective Shoes** ◯ **Orthotics in Shoes** ◯
- **Other Braces:**_______________________

Please list all medications and supplements:

____

____

____

____

Does your child have any allergies to the following?

- **Drugs:**____
- **Foods:**____
- **Environment:**____

Please check if your child has had any of the following:

- ◯ **Frequent Headaches**
- ◯ **Pinkeye**
- ◯ **Trouble hearing**
- ◯ **Stuffy nose most of the time**
- ◯ **Chronic Cough**
- ◯ **Heart Murmur**
- ◯ **Frequent Stomachaches**
- ◯ **Poor appetite**
- ◯ **Blood, red or brown urine**
- ◯ **Joint pains or swelling**
- ◯ **Inability to get to sleep**
- ◯ **Excessive thirst**
- ◯ **Signs of sexual development before 9 years old**
- ◯ **Crossed Eyes**
- ◯ **More than two earaches a year**
- ◯ **Frequent Nosebleeds**
- ◯ **More than 6 colds a year**
- ◯ **Shortness of breath with exercise**
- ◯ **Constant or Frequent Fatigue**
- ◯ **Frequent diarrhea or constipation**
- ◯ **Frequent bed-wetting after 5 years old**
- ◯ **Frequent urination or accidents**
- ◯ **Dizziness or fainting spells**
- ◯ **Frequent nightmares or sleepwalking**
- ◯ **Excessive weight gain**
- ◯ **Difficulty processing lots of simulation**

Other Concerns:____

Child Development:

At what age did your child…

- **Sit alone**_________ **Walk alone**_________ **Feed self**_________
- **Talk (2-3 sentences)**________ **Dress self**________ **Toilet trained**________ **at night?**_______

If your child is school age, what grade?_________ **Days missed this year?**________

Does your child have any challenges in school?

- ◯ **Reading/Writing** ◯ **Behavior** ◯ **Special Needs**
- **Please specify:**____

Does your child have behavior challenges at home? No ◯ **Yes** ◯ **If yes, in what way?**____________

Immunizations and Screenings:

Are immunizations up to date for the standard schedule? No ◯ **Yes** ◯

Are you doing a selective or delayed immunization schedule? No ◯ **Yes** ◯

When was the last vision exam?_______________

When was the last hearing exam?_______________

Has your child had a lead blood test done? No ◯ **Yes** ◯ **If yes, when and what was the result?**_____

Has the child had a hemoglobin test done? No ◯ **Yes** ◯ **If yes, when and what was the result?**_____