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pediatric intake form

child's name:_____ date:_____
your name:_____ relation to child:_____
address:_____city: _____state: _____ zip: _____
telephone(home): _____(cell):_____ (work): _____
email address: _____ preferred contact: home / cell / work / email
child's age: _____ date of birth: _____ gender: female / male
are parents: married or committed / separated / divorced with whom does child live: _____
how did you hear about my practice? _____
name of pediatrician: _____ phone:_____
most important health concerns:
1) _____
2) _____
3) _____
4) _____

medications (please circle)

aspirin	tylenol	homeopathic remedies
decongestants	anti-histamine	herbs/vitamins
antibiotics	ibuprofen	ritalin

other:_____
allergies to medications: _____

medical history (please circle)

chicken pox	measles	mumps
scarlet fever	pneumonia	rubella
tonsillitis	ear infections	strep throat
frequent colds	rheumatic fever	

other:_____

family history

is there a family history of any of the following? (please circle)

heart disease	hypertension	mental illness
diabetes	arthritis	osteoporosis
birth defects	tuberculosis	cancer
allergies	asthma	

other:_____

immunizations

____ mmr	____ diphtheria	____ rubella
____ dpt	____ influenza	____ polio
____ chicken pox	____ hepatitis b	others:_____
____ small pox	____ mumps	_____
____ measles	____ tetanus	adverse reactions: yes / no

has your child ever had any of the following? when? results?

electroencephalogram (eeg): _____
psychological evaluations: _____
hearing test: _____
speech/language tests: _____
injuries/surgeries/hospitalizations:_____

prenatal history

mother's age at child's birth: _____ history of miscarriage yes / no if so, when? _____

mother's health during pregnancy:

____ bleeding	____ illnesses	____ medications
____ nausea	____ hypertension	____ thyroid problems
____ physical or emotional trauma	____ cigarettes, alcohol, drug consumption	____ diabetes (type 1, type 2, gestational)

explaine:_____

birth history

term: full / premature if premterm, # of weeks_____ late length of labor: _____

where did you give birth? hospital / birthing center / home

any complications? _____

did you have any of the following: induced labor / epidural / episiotomy / cesarean birth

if cesarean birth, what was the cause? _____

did your child have any of the following problems shortly after birth?

rashes	birth defects	fever
birth injuries	jaundice	croup
blue baby	seizures	
colic	cerebral palsy	

other:_____

breast fed: y / n how long? _____ formula: y / n type: milk / soy / rice / other

age began solids:_____

age began: sitting _____ crawling _____ walking _____ talking _____

has your child experienced any of the following: (please circle)

hives	anemia	body/breath odor
burning urine	night sweats	constipation
bloody urine	high fevers	allergies
eczema	jaundice	stomach aches
bleeding gums	sensitivity to light	unusual fears
heart murmur	chronic rashes	excessive fatigue
nervousness	sore throats	nightmares
hair loss	diarrhea	frequent colds
nose bleeds	hearing loss	bleeding tendency
vomiting spells	easy bruising	frequent urination
sleep problems	cough	wheezing
asthma	flat feet	joint pains
acne	loss of appetite	dizzy spells

please describe your child's typical daily diet:

breakfast:_____

lunch:_____

dinner:_____

snacks:_____

drinks: _____

please read and sign below:

~I understand that although massage and bodywork can be therapeutic, relaxing and aid in healing, it is not a substitute for medical examination or diagnosis.

~since massage and bodywork should not be done under certain medical conditions, I affirm that I have answered all the questions pertaining to this child's medical conditions truthfully.

~the health and relationships of the family/parents/guardians/siblings may also play into the health concerns of this child. I agree to be open and honest about these matters, and I understand they are very important.

signiature:_____ date:_____

thank you ~ I look forward to helping you and your child in any way that I can!