



Pediatric Intake (Birth to 8 Years)

Patient's Name: _____ Date: _____

Age: _____ Date of Birth: _____ Sex: _____

Parent/ Guardian's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone (home): _____ Parent's work/cell: _____

Parent's email address: _____

How did you hear about this clinic? _____

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

Name of doctor's clinic/hospital where your child's health records are kept: _____

What are your major concerns about your child's health?

1. _____

2. _____

3. _____

4. _____

Medications:

NOW PAST

___ ___ Aspirin

___ ___ Tylenol

___ ___ Antibiotics

___ ___ Ibuprofen

NOW PAST

___ ___ Decongestants

___ ___ Anti-histamine

___ ___ Other _____

Allergies to Medications: _____

Medical History:

___ Chicken Pox

___ Measles

___ Mumps

___ Rubella

___ Scarlet Fever

___ Pneumonia

___ Frequent Colds

___ Rheumatic fever

___ Tonsillitis

___ Ear infections

___ Strep throat

___ Asthma

___ Allergies

___ Colic

___ Croup

___ Other: _____

Date of last physical exam: _____

Date of last dental exam, if applicable: _____



Has your child ever had any of the following? Please include when, where and results.

Electroencephalogram (EEG): _____

Psychological evaluations: _____

Hearing test: _____

Speech/language tests: _____

Injuries/surgeries/hospitalizations (please list): _____

Immunizations:

<input type="checkbox"/> MMR	<input type="checkbox"/> Tetanus	Others: _____
<input type="checkbox"/> Measles	<input type="checkbox"/> Polio	Adverse Reactions? Y/N
<input type="checkbox"/> Mumps	<input type="checkbox"/> Chicken Pox	If so, what?
<input type="checkbox"/> Rubella	<input type="checkbox"/> Small Pox	_____
<input type="checkbox"/> DPT	<input type="checkbox"/> H. flu	_____
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Flu virus	

Family History:

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Allergies	Other significant:
<input type="checkbox"/> Cancer	<input type="checkbox"/> Osteoporosis	_____
<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Birth Defects	_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis	

Prenatal History:

Mother's age at child's birth: _____ Prenatal care? Y / N
Difficulty conceiving? Y / N Infertility treatments used? Y / N
Mother's health during pregnancy:
 Bleeding Diabetes
 Illnesses Physical or emotional trauma
 Medications Thyroid issues
 Nausea Drug or Alcohol Dependency
 Other: _____

Birth History:

Term: Full Premature Late Weight at birth: _____
Length of labor: _____
Complications: _____

Did your child have any of the following shortly after birth?

<input type="checkbox"/> Rashes	<input type="checkbox"/> Birth injuries	<input type="checkbox"/> Blue Baby
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Seizures	<input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> Colic	<input type="checkbox"/> Fever	<input type="checkbox"/> Birth Defects



Feeding/Diet History:

Breasts fed? Y / N How long? _____

Formula fed? Y / N How long? _____ What type? _____

Food intolerances? _____

Age began solids: _____ Which foods? _____

Does your child have any dietary restrictions? (religious, vegetarian, etc.)

Describe Child's Typical Daily Diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

Number of bottles given per day: _____

Health and Development:

How was your child's health in the first year? Poor Fair Good Excellent Unknown

At what age did your child first:

Sit Up: _____ Crawl: _____ Walk: _____ Talk: _____

Describe your child's sleep pattern: _____

Environment:

Is your child in:

___ School (grade ___) ___ Daycare ___ Homecare ___ Other: _____

What are your child's favorite activities? _____

Does your child exercise regularly? Y / N

How much and how often? _____

How much TV does your child watch? _____ hrs a day/week

Does anybody in the house smoke? Y / N

Are there any animals in the house? Y / N Type: _____

How would you describe the emotional climate of the child's home?



DECLARATION AND CONSET TO TREATMENT OF A CHILD

Child's name: _____ Date: _____

I, _____, hereby give my consent for the practitioners of Sages' Healing Center to treat my child or ward. I take responsibility for all fees incurred.

Signature: _____ Date: _____

Relationship to child: _____

Witness's signature: _____ Date: _____