Pediatric Intake (6-12 years)

Patient's name: ____ Date: ____________

Age: ____________ Date of Birth: ______________________ Sex: ____________

Parent / Guardian's Name: ____

Address: ____

City: _____________________________ State: ___________ Zip: ____________

Telephone (home): ___________________ Parent's cell: ______________________

Parent's email address: ____

How did you hear about our 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: __________

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

1. ____
2. ____
3. ____

Does your child have a contagious disease at this time? Y / N

If yes, what? ____

Please list **any** prescription medications, over the counter medications, vitamins or other supplements your child is taking:

1. ______________________________ 2. ______________________________

3. ______________________________ 4. ______________________________

5. ______________________________ 6. ______________________________

Medical History:

☐ Chicken Pox ☐ Frequent Colds ☐ Allergies ☐ Ear Infections

☐ Scarlet Fever ☐ Pneumonia ☐ Strep Throat ☐ Asthma

☐ Other: ____

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

Electroencephalogram (EEG): ____

Psychological Evaluation:____

Hearing Test:____

Injuries/Surgeries/Hospitalizations (please list): ______________________________

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Immunizations:

☐ MMR ☐ Tetanus ☐ DTaP ☐ Chicken Pox ☐ Influenza

☐ H. flu ☐ Hep B Others: ____________________________________

Adverse Reactions? ____

Typical Food Intake:

Describe Child's Typical Daily Diet:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Drinks: ____

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

____

Allergies:

Is your child hypersensitive or allergic to:

Any drugs? ____

Any foods? ____

Any environmental? ____

Breast fed? Y / N How long? _________ Formula? _________ Milk / soy

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 TV does your child watch? _____Hours 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 in your child's home?

____

____

REVIEW OF SYSTEMS

Y = a new condition P = a condition in the past N = never had

MENTAL/ EMOTIONAL

Mood Swings	Y	P	N	Anxiety/nervousness	Y	P	N
Irritability	Y	P	N	Cries easily	Y	P	N
Hyperactivity	Y	P	N	Unusual fears	Y	P	N
Introvert/extrovert	Y	P	N	Sleep Problems	Y	P	N
Motion/car sickness	Y	P	N	Nightmares	Y	P	N

ENDOCRINE

Heat/cold intolerance	Y	P	N	Fatigue	Y	P	N
Excessive thirst	Y	P	N	Excessive hunger	Y	P	N
Low blood sugar	Y	P	N	High blood sugar	Y	P	N

SKIN

Rashes	Y	P	N	Eczema, hives	Y	P	N
Acne, boils	Y	P	N	Itching	Y	P	N

HEAD

Headaches	Y	P	N	Head Injury	Y	P	N
Dizzy spells	Y	P	N	High fevers	Y	P	N

EYES/EARS/NOSE/MOUTH/THROAT

Glasses/contacts	Y P N	Sinus problems	Y P N
Eye pain/strain	Y P N	Nose bleeds	Y P N
Tearing or dryness	Y P N	Seasonal allergies	Y P N
Earaches	Y P N	Loss of smell	Y P N
Hearing Impaired	Y P N	Frequent sore throat	Y P N
Frequent colds	Y P N	Breath odor	Y P N
Stuffiness	Y P N	Canker sores	Y P N

CARDIOVASCULAR

Heart Disease	Y P N	Murmurs	Y P N

URINARY

Frequent urination	Y P N	Bed wetting	Y P N

GASTROINTESTINAL

Belching/ passing gas	Y P N	Stomach aches	Y P N
Constipation	Y P N	Diarrhea	Y P N

How many bowel movements per day? ____

MUSCULOSKELETAL

Joint pain/stiffness	Y P N	Muscle spasms/cramps	Y P N
Broken bones	Y P N		

BLOOD/PERIPHERAL VASCULAR

Anemia	Y P N	Easy bleeding/bruising	Y P N

Is there any information about your child's health that you would like to add?

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Welcome! We're glad to be of service to you and your child!

<u>**DECLARATION AND CONSENT TO TREATMENT OF A CHILD**</u>

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: ____