Initial Intake Form - Pediatrics

Today's Date ____________________Referred by_______________________________

Child's Name____________________ DOB________ Diagnosis___________________

Mother's name___________________ Father's name_____________________________

Telephone @ home________________ Work________________ Cell________________

Address____

Pediatrician_____________________ Telephone_________________________________

Insurance Company ______________ Dept of Ed __________E.I.P__________________

School ___________________________Telephone ________Teacher________________

Emergency Contact ______________________Telephone___________________________

GENERAL HEALTH HISTORY

Describe your pregnancy, labor, delivery____

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Was your child Full term Premature Gestational Age _____Birth weight _______

Has your child ever been hospitalized? ____

Was your child Breast fed Bottle fed? Did child transition easily to solids_________

At what age did your child: Sit ______Crawl ____Walk ___Talk_____________________

____

Who lives at home _____________Siblings ________Any developmental issues or illnesses in family

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Has your child ever been treated for?

Asthma Allergies Ear infections Feeding Problems Food hypersensitivities

Gastrointestinal Problems Headaches Major illness or injury Seizures

Sensory or motor issues Sleep Problems Other___________________________

Comments____

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Has your child seen any of the following specialists?

Developmental Pediatrician Neurologist Psychiatrist Audiologist

Occupational Therapist Physical Therapist Speech and Language Therapist

Neuropsychologist Osteopath Chiropractor Homeopath Nutritionist

Psychotherapist Special Educator

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Areas of concern____

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Please Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office.

________________________ ___________________ _____________________

Name of Parent/Legal Guardian Signature Date