vitality
WELLNESS CLINIC

New Pediatric Patient Intake

Please fill out as much information as possible. You can either type your responses, save the pdf and then email the completed form to us at **office@vitalitynhc.com**. Or, you can print out the form, write your answers and then bring it with you on your next visit.

Patient Name: _____ DOB: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Sex: ☐ M / ☐ F Grade of School: _____ Nickname: _____

Mother's Name: _____ Occupation: _____

Father's Name: _____ Occupation: _____

Parents are: ☐ Married / ☐ Separated Divorced / ☐ Living Together / ☐ Other: _____

Reason for Office Visit: _____

Has child been seen by any other doctor(s) for this complaint? ☐ Y/ ☐ N / ☐ Past

Regular Pediatrician name & phone number: _____

Last time any blood work was done and with what physician: _____

List ALL Surgeries & Hospitalizations, including date occurred: _____

1) _____ 3) _____

2) _____ 4) _____

List ALL medicines (from drugstore or prescription) child is currently taking:

1) _____ 3) _____

2) _____ 4) _____

List ALL Supplements the child is currently taking:

1) _____ 3) _____

2) _____ 4) _____

Any known Allergies to foods, drugs, environment, animals:

_____

_____

Previous Medical History

YES (Y) indicates the child gets the problem regularly
NO (N) indicates the child never had the problem
PAST (P) indicates the child had the problem in the past, but not recently

Please check the correct answer for your child:

Ear Infections: ☐ Y / ☐ N / ☐ P If has had, how many times? _____

Colds: ☐ Y / ☐ N / ☐ P If has had, how many times? _____

Strep Throat: ☐ Y / ☐ N / ☐ P If has had, how many times? _____

How many times has the child taken antibiotics? _____

What other medicines has the child taken and how often? _____

1) _____ 3) _____

2) _____ 4) _____

Hearing Test Normal:☐ Y /☐ N /☐ Not Tested

Vision Test Normal: ☐ Y / ☐ N / ☐ Not Tested

Speech Impediments: ☐ Y / ☐ N / ☐ Not Tested

Learning Impediments: ☐ Y / ☐ N / ☐ Not Tested

Vaccination History

YES (Y) has had **NO (N)** has not had **SOME (S)** did not finish all shots

MMR: ☐ Y / ☐ N / ☐ S DPT: ☐ Y / ☐ N / ☐ S Hep B: ☐ Y / ☐ N / ☐ S

Hib: ☐ Y / ☐ N / ☐ S Chicken Pox: ☐ Y / ☐ N / ☐ S Polio: ☐ Y / ☐ N / ☐ S

Other: _____

Any reactions to vaccinations? If yes, please explain:

_____

_____

Family History

Conditions	Father	Mother	Mother's Mom	Mother's Dad	Father's Mom	Father's Dad	Sibling
Allergies:	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Cancer:	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Diabetes:	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
GI Disease:	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Heart Disease:	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Kidney Disease:	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Lung Disease:	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Metal Illness:	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Tuberculosis:	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N
Vision/Hearing Impaired:	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N	☐ Y / ☐ N

Mother's Pregnancy History

Age at conception: _____ Is this the first child? ☐ Y / ☐ N

Due date: _____ When did you start seeing the doctor? _____

Mother's Health During Pregnancy

During Pregnancy did you:

Have High Blood Pressure? ☐ Y / ☐ N

Have gestational diabetes? ☐ Y / ☐ N

Take any medicines? ☐ Y / ☐ N

Smoke cigarettes? ☐ Y / ☐ N

Drink alcohol? ☐ Y / ☐ N

Use other drugs? ☐ Y / ☐ N

Nausea / Vomiting? ☐ Y / ☐ N

Emotional stress? ☐ Y / ☐ N

Drink coffee? ☐ Y / ☐ N

Was child premature? ☐ Y / ☐ N

Was baby breech? ☐ Y / ☐ N

Was it a cesarean delivery? ☐ Y / ☐ N

If the birth was difficult, please explain:

_____

_____

What is Mother's blood type? _____ What is child's blood type? _____

Place of Child's birth: _____ Name of OB/Midwife/Doula: _____

Health of baby at birth: _____

_____

Health History of Child

Baby's Birth Weight: _____ Baby's Birth Length: _____ Head Circumference: _____

Did baby breathe / cry immediately? ☐ Y / ☐ N Was baby jaundiced at birth? ☐ Y / ☐ N

Was PKU testing done at birth? ☐ Y / ☐ N Was child breastfed: ☐ Y / ☐ N

If so, for how long? _____

Formula: ☐ Y / ☐ N At what age? _____ Kind used: _____

When was child put on solid foods? _____

Any problems/Allergies/Sensitivities: _____

Jaundice As Baby:	☐ Y / ☐ N	Colic:	☐ Y / ☐ N
Cradle Cap:	☐ Y / ☐ N	Anemia:	☐ Y / ☐ N
Eczema or Psoriasis:	☐ Y / ☐ N	Asthma:	☐ Y / ☐ N
Diarrhea:	☐ Y / ☐ N	Warts:	☐ Y / ☐ N
Constipation:	☐ Y / ☐ N	Nightmares:	☐ Y / ☐ N
Finicky Eating:	☐ Y / ☐ N	Bed Wetting:	☐ Y / ☐ N
Poor Teeth:	☐ Y / ☐ N	Tantrums:	☐ Y / ☐ N
Chronic Sniffles:	☐ Y / ☐ N	Disobedient:	☐ Y / ☐ N
Bad Foot Odor:	☐ Y / ☐ N	Fears/Phobias:	☐ Y / ☐ N
Very Sweaty Baby/Child:	☐ Y / ☐ N	Diaper Rash:	☐ Y / ☐ N
Hyperactivity:	☐ Y / ☐ N	Early Puberty:	☐ Y / ☐ N
Growing Pains:	☐ Y / ☐ N	Stomach Aches:	☐ Y / ☐ N

Has the child experienced, witnessed or gone through, any household stressors?

_____

_____

Social Development History

Mother's age: _____ Father's age: _____

Child has how many sisters? _____ Brothers? _____

Child is the oldest, middle, or youngest in the family? _____

Other children's ages: _____

Who spends the most time caring for the child? _____

Does the child go to daycare/babysitter/preschool on a regular basis? ☐ Y / ☐ N

Are there any pets in the home? ☐ Y / ☐ N How many? _____ Type? _____

Any smokers in the home? ☐ Y / ☐ N

At what age did the child: ☐ Sit up? ☐ Crawl? ☐ Walk? ☐ Start talking?

Concerns / Problems

Does your baby/child have any on-going problem(s) that concern you?

Please check all that apply:

☐ Eats too little	☐ Eats too much	☐ Speaks unclearly
☐ Cries a lot	☐ Has frequent temper tantrums	☐ Wets bed
☐ Difficulty sleeping	☐ Frequently constipated	☐ Small for age
☐ School problems	☐ Behavior problems	☐ Sees poorly
☐ Doesn't always respond to noise / spoken words		☐ Runny noses/cough

Are there any other problems / concerns?

_____

_____

_____

_____

Typical Day's Diet

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Snacks: _____

_____

Toxin Exposure

Has the child ever lived near a refinery, polluted area or in a home with leaded paint? If so, what was the child exposed to? _____

Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health at all? _____

Does the child seem particularly sensitive to perfumes, gasoline or other vapors? _____

Do you spray pesticides, herbicides or other chemicals around your home? _____

How did you hear about our office?

_____

Print Name _____ **Sign Name** _____ **Date** _____