

**CHILD INTAKE FORM**

Name: \_\_\_\_\_ Birthdate \_\_\_\_\_

Contact Address: \_\_\_\_\_

City, Zip: \_\_\_\_\_ Sex: M F Weight \_\_\_ Height \_\_\_

Home Phone: \_\_\_\_\_

Mother's Name \_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_

Main Email Address \_\_\_\_\_

Siblings (Include ages): \_\_\_\_\_

Pediatrician (Include name and address): \_\_\_\_\_

Referred by \_\_\_\_\_

Current School (Include Grade): \_\_\_\_\_

Contact in case of emergency \_\_\_\_\_

Birth History (Include birth weight, problems during pregnancy or afterbirth)

\_\_\_\_\_  
\_\_\_\_\_

Give the following information for the last times your child has been hospitalized starting with the most recent including type of illness, month and year hospitalized, name of hospital, city and state.

#1: \_\_\_\_\_

#2: \_\_\_\_\_

#3: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications(Type, Dosage, Frequency): \_\_\_\_\_

Medicinal Herbs, Vitamins, Teas: \_\_\_\_\_

Does your child use: Coffee: Amount \_\_\_\_\_ Cigarettes: \_\_\_\_\_

Alcohol: Amount \_\_\_\_\_ Other drugs: Amount \_\_\_\_\_

YEAR Tests  
\_\_\_\_\_ · MMR  
\_\_\_\_\_ · DPT  
\_\_\_\_\_ · TB test  
\_\_\_\_\_ · Typhoid  
\_\_\_\_\_ · Other x-rays

YEAR Immunizations  
\_\_\_\_\_ · Smallpox  
\_\_\_\_\_ · Tetanus  
\_\_\_\_\_ · Polio  
\_\_\_\_\_ · Hepatitis  
\_\_\_\_\_ · Other

CHECK yes only if your child has recently been bothered by any of these problems.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> frequent or severe headaches | <input type="checkbox"/> recurring indigestion    | <input type="checkbox"/> aching muscles or joints |
| <input type="checkbox"/> back pains                   | <input type="checkbox"/> frequent belching        | <input type="checkbox"/> swollen joints           |
| <input type="checkbox"/> neck lumps or swelling       | <input type="checkbox"/> nausea                   | <input type="checkbox"/> back or shoulder pains   |
| <input type="checkbox"/> loss of balance              | <input type="checkbox"/> vomiting                 | <input type="checkbox"/> weakness in arms or legs |
| <input type="checkbox"/> dizzy spells                 | <input type="checkbox"/> pain in abdomen          | <input type="checkbox"/> painful feet             |
| <input type="checkbox"/> blackouts/fainting           | <input type="checkbox"/> bloated abdomen          | <input type="checkbox"/> trembling                |
| <input type="checkbox"/> wear glasses                 | <input type="checkbox"/> constipation             | <input type="checkbox"/> numbness                 |
| <input type="checkbox"/> blurry vision                | <input type="checkbox"/> loose bowels             | <input type="checkbox"/> leg cramps               |
| <input type="checkbox"/> eyesight worsening           | <input type="checkbox"/> black stools             | <input type="checkbox"/> skin problems            |
| <input type="checkbox"/> see double                   | <input type="checkbox"/> grey or whitish stools   | <input type="checkbox"/> scalp problems           |
| <input type="checkbox"/> see halos or lights          | <input type="checkbox"/> pain in rectum           | <input type="checkbox"/> itching or burning skin  |
| <input type="checkbox"/> eye pains or itching         | <input type="checkbox"/> itching rectum           | <input type="checkbox"/> bruise easily            |
| <input type="checkbox"/> watering eyes                | <input type="checkbox"/> blood with stools        | <input type="checkbox"/> nervousness or anxiety   |
| <input type="checkbox"/> earaches                     | <input type="checkbox"/> frequent urination       | <input type="checkbox"/> nervous with strangers   |
| <input type="checkbox"/> hearing difficulties         | <input type="checkbox"/> involuntary urination    | <input type="checkbox"/> nail biting              |
| <input type="checkbox"/> running ears                 | <input type="checkbox"/> burning on urination     | <input type="checkbox"/> diff. making decisions   |
| <input type="checkbox"/> noises in ears               | <input type="checkbox"/> black or bloody urine    | <input type="checkbox"/> lack of concentration    |
| <input type="checkbox"/> dental problems              | <input type="checkbox"/> weak urine stream        | <input type="checkbox"/> loss of memory           |
| <input type="checkbox"/> sore or bleeding gums        | <input type="checkbox"/> diff. starting urine     | <input type="checkbox"/> lonely or depressed      |
| <input type="checkbox"/> sore tongue                  | <input type="checkbox"/> constant urge to urinate | <input type="checkbox"/> frequent crying          |
| <input type="checkbox"/> congested nose               | <input type="checkbox"/> hopeless outlook         |   |
| <input type="checkbox"/> running nose                 | <input type="checkbox"/> difficulty relaxing      |   |
| <input type="checkbox"/> sneezing spells              | <input type="checkbox"/> worry a lot              | <b>Men/Boy only</b>                               |
| <input type="checkbox"/> head colds                   | <input type="checkbox"/> scary dreams or thoughts | <input type="checkbox"/> burning or discharge     |
| <input type="checkbox"/> nosebleeds                   | <input type="checkbox"/> feeling of desperation   | <input type="checkbox"/> swelling on testicles    |
| <input type="checkbox"/> sore throat                  | <input type="checkbox"/> shy or sensitive         | <input type="checkbox"/> painful testicles        |
| <input type="checkbox"/> difficulty swallowing        | <input type="checkbox"/> dislike criticism        |   |
| <input type="checkbox"/> hoarse voice                 | <input type="checkbox"/> angered easily           | <b>Women/Girls only</b>                           |
| <input type="checkbox"/> wheezing or gasping          | <input type="checkbox"/> annoyed by little things | <input type="checkbox"/> a missed period          |
| <input type="checkbox"/> frequent coughing            | <input type="checkbox"/> family problems          | <input type="checkbox"/> menstrual problems       |
| <input type="checkbox"/> cough up phlegm              | <input type="checkbox"/> problems at work/school  | <input type="checkbox"/> bleeding between periods |
| <input type="checkbox"/> cough up blood               | <input type="checkbox"/> sexual difficulties      | <input type="checkbox"/> heavy bleeding           |
| <input type="checkbox"/> chest colds                  | <input type="checkbox"/> change of sexual energy  | <input type="checkbox"/> bearing down feeling     |
| <input type="checkbox"/> rapid or skipped heart beats | <input type="checkbox"/> considered suicide       | <input type="checkbox"/> vaginal discharge        |
| <input type="checkbox"/> chest pains                  | <input type="checkbox"/> loss or gain in weight   | <input type="checkbox"/> genital irritation       |
| <input type="checkbox"/> shortness of breath          | <input type="checkbox"/> loss of appetite         | <input type="checkbox"/> pain on intercourse      |
| <input type="checkbox"/> swollen feet or ankles       | <input type="checkbox"/> always hungry            | <input type="checkbox"/> swelling in breasts      |
| <input type="checkbox"/> armpits or groin swelling    | <input type="checkbox"/> fatigue or weariness     | <input type="checkbox"/> painful breasts          |
| <input type="checkbox"/> difficulty sleeping          | <input type="checkbox"/> fever or chills          | <input type="checkbox"/> #of pregnancies          |
| <input type="checkbox"/> motion sickness              | <input type="checkbox"/> night sweats             | <input type="checkbox"/> #of births               |
| <input type="checkbox"/> excessive sweating           | <input type="checkbox"/> hot flashes              | <input type="checkbox"/> #of miscarriages         |
|   | <input type="checkbox"/> warm/colder than others  | <input type="checkbox"/> #of caesareans           |
|   |   | <input type="checkbox"/> # of abortions           |

**Main Reason for Visit Today/Comments or Special Problems:**

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What are you most sensitive to (eg. noise, odors, light, pain)? \_\_\_\_\_

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Describe an ideal day in terms of weather and temperature: \_\_\_\_\_

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What are your fears? \_\_\_\_\_

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Do you have any hobbies? \_\_\_\_\_

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(Women only) What symptoms do you experience premenstrually? \_\_\_\_\_

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Describe any recurrent dreams, important dreams in your life or recurrent themes in your dreams: \_\_\_\_\_

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How is your energy? Is there any particular time of day when it is lower or higher? \_\_\_\_\_

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What environment do you feel most comfort in? (ie desert, mountains, ocean, city) \_\_\_\_\_

What do you most like to eat or crave? \_\_\_\_\_

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What is your favorite color? \_\_\_\_\_

What foods do you most dislike? \_\_\_\_\_

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How is your thirst? \_\_\_\_\_

What temperature do you like fluids? \_\_\_\_\_

Are there any foods that you are sensitive to or allergic to? \_\_\_\_\_

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