649 Fillmore St. NE
Minneapolis, MN 55413
(612) 564-5511

Pediatric Intake Form

Date:____/____/______

Child's Name______________________________Date of Birth_____/____/_____Sex___
Address____
City___________________ State______ Zip________________
Grade in school:____________ School:____________________________

Mom's name____Occupation_______________
Phone number_____________________
Dad's name____Occupation_______________
Phone number_____________________
Parents are: married separated divorced living together other

Who should we contact in case of emergency?
Name ____________________________ Relationship ______________________
Phone Number_____________________
Address____
City___________________ State______ Zip________________
Pediatrician's name and location____

Top 3 Reasons for visit
1. ____
2. ____
3. ____

Has your child been seen by any other doctor(s) for these reasons?_________________
Please list any hospitalizations/surgeries and dates when they occurred:
____
____

Please list all medicines & supplements your child is taking (prescribed/over the counter):
____

History:

Was the pregnancy planned? Y/N Age at conception:_______
Prenatal Vitamins: Y/N Brand:__________ Date started:_____________

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Health during pregnancy:

Diabetes	Y/N	Preeclampsia	Y/N	Medication taken	Y/N
Caffeine	Y/N	Smoking	Y/N	Recreational drugs	Y/N
Nausea	Y/N	Vomiting	Y/N	Emotional Stress	Y/N

Birth Location: Hospital Birthing Center Home

Name of Obstetrician/Midwife:____

Position during Labor: Back Semi-Sit Fours Position Squatting

Intervention: None Epidural Ptosin Episiotomy Forceps Vacuum C-Section
Length of Labor: ________ hours
Neonatal Health: Weight_______ Inches__________

How long was your child breast fed?_________ Difficulty latching? Y/N
How many hours does your child sleep during the night?____________

Does your child have any of the following conditions? Is there a family history?
(C=Current, P=Past, M=Mother, F=Father, B=Brother, S=Sister)

Asthma ____________________ Age_____
Bladder Infection_____________ Age_____
Chicken Pox_________________ Age_____
Colic________________________ Age_____
Constipation_________________ Age_____
Diarrhea_____________________ Age_____
Ear Infection________________ Age_____
Eczema______________________ Age_____
Finicky Eating_______________ Age_____
Rashes______________________ Age_____
Strep Throat_________________ Age_____
Tantrums____________________ Age_____

Learning impediments____
Speech impediments____

Known Allergies to food, medicines, pollens, dander, perfumes etc:

____

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Vaccination history:

DPT	Y/N	Age_____
DT	Y/N	Age_____
Hepatitis	Y/N	Age_____
Tetanus Only	Y/N	Age_____
H. Inf. (HiB)	Y/N	Age_____
Polio	Y/N	Age_____
MMR	Y/N	Age_____
Chicken Pox	Y/N	Age_____

Please list any reactions to the vaccines________________________________
____

Family Medical History (C=Current, P=Past, M=Mother, F=Father, B=Brother, S=Sister)

Allergies______________________ Cardiovascular Disease_____________
Cancer _______________________ Obesity __________________________
Diabetes_______________________ Mental Illness_____________________

Typical Day's Diet (please include beverages)

Breakfast____
____
Snack____
____
Lunch____
____
Snack____
____
Dinner____
____
Snack____
____

Patient's signature ____ Date __________
Spouse's or guardian's signature __________________________________ Date __________

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