CONFIDENTIAL PATIENT HEALTH HISTORY

Please PRINT clearly.

Today's Date: ______________________

PATIENT INFORMATION

Name: (Last, First, MI) ____ **Preferred Name:** ____________________

Address: ____ **City:** ____________________ **State:** ________ **Zip:** __________

Home Phone: ____________________ **Mobile:** __________________________ **Work:** ______________________________

Email: ____ **Gender:** M / F **Marital Status:** Married / Single / Other

Date of Birth: __________________ **Occupation:** _________________________ **Employer:** __________________________

Spouse/Significant Other: ______________________ **Children and Ages:** ____

Are you: Military Veteran / Active Duty Service Member / Reservist / National Guard / ROTC

Referred by *(name)*: ____

☐ **Family** ☐ **Friend** ☐ **Co-Worker** ☐ **Doctor** ☐ **Other:** __________________

-CMS requires providers to report both race and ethnicity-

Ethnicity: Not Hispanic or Latino / Hispanic or Latino / Other / Decline to Answer **Preferred Language:** __________________

Race: Asian / Black or African American / American Indian or Alaskan Native / White (Caucasian) / Hawaiian or Pacific Islander / Other / Decline

Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: ___________________________________ **Preferred Contact Number:** _________________________________

Relationship: Child / Parent / Spouse / Other: ________

Primary Care Physician: ____________________________ **Doctor's Phone:** ____

FINANCIAL INFORMATION -- *Please allow us to photocopy your insurance card.*

Self Pay (Cash) **Insurance** **Personal Injury/Auto** **Other (please explain)** ____________________

PRIMARY INSURANCE: __________________________ **SECONDARY INSURANCE:** ______________________________

Policy Holder: _________________________________ **Policy Holder:** ____________________________________

Relation to Insured: Self / Spouse / Parent / Child / Other **Relation to Insured:** Self / Spouse / Parent / Child / Other

Pediatric Intake Form

Current Health Conditions

What are the primary health concerns for your child?

____

____

____

____

Please describe when your child's issues first began and how they've progressed since:

____

____

What makes things better?

____

____

What makes things worse?

____

____

Labor and Delivery History

Child's birth was:

☐ Vaginal Birth ☐ Scheduled C-Section ☐ Emergency C-Section

At how many weeks was your child born? ______________________

Please check any applicable interventions or complications:

☐ Breech ☐ Induction ☐ Pain Meds ☐ Manual Assistance

☐ Epidural ☐ Episiotomy ☐ Vacuum Extraction ☐ Forceps ☐ Cord-Wrapped

Growth and Development History

Is/Was your child breastfed?

☐ Yes ☐ No

If yes, how long?

____

Did they ever use formula?

☐ Yes ☐ No

If yes, at what age?

____

Did/Does your child ever suffer from colic, reflux, skin issues, or constipation as an infant?

☐ Yes ☐ No

If yes, please explain:

____

____

____

____

At what age did the child:

	Age
Respond to sound:	
Follow an object:	
Hold their head up:	
Vocalize:	
Start Teething:	
Sit alone:	
Crawl:	
Walk:	
Begin cow's milk:	
Begin solid foods:	

Please list any food intolerance or allergies, and when they began:

	Food Intolerance/Allergy	When they began
1		
2		
3		

Please list your child's hospitalization and surgical history, including the year:

	Hospitalization/Surgery	Year
1		
2		
3		

Have you chosen to vaccinate your child?

☐ No ☐ Yes, on a delayed or selective schedule

☐ Yes, on schedule

Has your child received any antibiotics?

☐ Yes ☐ No

How would you describe your child's diet?

☐ Mostly whole, organic foods ☐ Pretty average

☐ High amount of processed foods

Patient Review of Systems

The nervous system controls and coordinates all organs and structures of the human body.

Please check the corresponding boxes for each symptom or condition your child has experienced – including both past and present

Colic & Excessive Crying
☐ Past ☐ Present

Difficulty Latching/Nursing
☐ Past ☐ Present

Reflux & Excessive Spit Up
☐ Past ☐ Present

Projectile Vomiting
☐ Past ☐ Present

Frequent Stiffening, Rigidity, Arching
☐ Past ☐ Present

Difficulty Sleeping
☐ Past ☐ Present

Torticollis
☐ Past ☐ Present

Plagiocephaly
☐ Past ☐ Present

Motor Milestone Delays
☐ Past ☐ Present

Low Tone & Coordination Challenges
☐ Past ☐ Present

Speech & Communication Delays
☐ Past ☐ Present

Sensory Processing Challenges
☐ Past ☐ Present

Social/Emotional Challenges
☐ Past ☐ Present

Frequent Tantrums & Meltdowns
☐ Past ☐ Present

Behavior Issues
☐ Past ☐ Present

Hyperactivity & Impulsivity
☐ Past ☐ Present

Anxiety & Emotional Instability
☐ Past ☐ Present

ADHD/ADD
☐ Past ☐ Present

Balance & Coordination Issues
☐ Past ☐ Present

Visual & Auditory Processing Challenges
☐ Past ☐ Present

Handwriting & Fine Motor Challenges
☐ Past ☐ Present

Low Energy & Fatigue
☐ Past ☐ Present

Depression & Lack of Confidence
☐ Past ☐ Present

Lightheadedness & Dizziness
☐ Past ☐ Present

Frequent Nausea & Malaise
☐ Past ☐ Present

Headaches & Migraines
☐ Past ☐ Present

Stiff Neck & Shoulders
☐ Past ☐ Present

Jaw, Swallowing, Sensory Food Aversions
☐ Past ☐ Present

Vision & Hearing Issues
☐ Past ☐ Present

Ear & Sinus Infections
☐ Past ☐ Present

Sore Throat & Strep
☐ Past ☐ Present

Swollen Tonsils & Adenoids
☐ Past ☐ Present

Strep & Upper Respiratory Infections
☐ Past ☐ Present

Allergies & Autoimmune Challenges
☐ Past ☐ Present

Chronic Inflammation
☐ Past ☐ Present

Poor Metabolism & Weight Control
☐ Past ☐ Present

Chronic Chest Colds & Cough
☐ Past ☐ Present

Bronchitis & Pneumonia
☐ Past ☐ Present

Asthma
☐ Past ☐ Present

Blood Sugar Problems
☐ Past ☐ Present

Skin Conditions/Rash
☐ Past ☐ Present

Ulcerative Colitis, Crohn's, IBS
☐ Past ☐ Present

Kidney Challenges
☐ Past ☐ Present

Gas Pain & Bloating
☐ Past ☐ Present

Gluten & Casein Intolerance
☐ Past ☐ Present

Constipation
☐ Past ☐ Present

Bladder & Urination Issues
☐ Past ☐ Present

Hormonal Challenges
☐ Past ☐ Present

Low Back Pain & Stiffness
☐ Past ☐ Present

Lumbopelvic/SI Joint Pain
☐ Past ☐ Present

Tight Hamstrings & Calves
☐ Past ☐ Present

Toe Walking
☐ Past ☐ Present

Poor Circulation & Cold Feet
☐ Past ☐ Present

Weak Ankles & Arches
☐ Past ☐ Present