2100 SW Camelot Ct
Portland, OR 97225
P: (503) 252-8125
F: (503) 256-8422

PEDIATRIC INTAKE FORM (BIRTH TO 5 YEARS)

Patient's Name: ______________________________ Date: ____________

Age: ________ Date of Birth: ______________________ Gender: Female / Male

Parent/Guardian's Name: ______________________________

Insurance Plan: ______________________________

Address: ______________________________

City: ____________________ State: ________ Zip: ________

Telephone (home): ________________ (Parent's work): ________________

Parent's email address: ______________________________

How did you hear about this clinic? ______________________________

If internet: Google:___ AANP Website:___ OANP Website:___ Other:____________

Has any other family member already been a patient at this clinic? Yes / No ____________

Name of doctor's office/hospital/clinic where your child's health records are kept: ____________

____

Reason for referral or presenting problems: ______________________________

____

MEDICATIONS

NOW	PAST		NOW	PAST	
___	___	Aspirin	___	___	Decongestants
___	___	Tylenol	___	___	Anti-histamine
___	___	Antibiotics	___	___	Other ____________
___	___	Ibuprofen	Allergies to medicines: ____________		

MEDICAL HISTORY

___	Chicken pox	___	Scarlet fever	___	Tonsillitis, approx no. of times: ________
___	Measles	___	Pneumonia	___	Ear infections, approx no. of times: ________
___	Mumps	___	Frequent colds	___	Strep throat, approx no. of times: ________
___	Rubella	___	Rheumatic fever	___	Other: ____________

Has your child ever had any of the following? WHEN WHERE RESULTS

Electroencephalogram (EEG): ______________________________

Psychological evaluations: ______________________________

Hearing test: ______________________________

Speech/language tests: ______________________________

Injuries/surgeries/hospitalizations (please list): ______________________________

____

IMMUNIZATIONS

___	MMR	___	DPT	___	Chicken pox	Others: ____________
___	Measles	___	Diphtheria	___	Small pox	Adverse reactions: Y / N
___	Mumps	___	Tetanus	___	H. influenza	If so, what? ____________
___	Rubella	___	Polio	___	The flu	____________

PT: ____________

PT DOB: ____________

Canyon Medical Center

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FAMILY HISTORY

___ Heart disease ___ Diabetes ___ Birth defects
___ Hypertension ___ Arthritis ___ Tuberculosis
___ Cancer ___ Allergies ___ Asthma
___ Mental illness ___ Osteoporosis ___ Other significant: ______________________________

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications? ______________________________
____
Mother's age at child's birth: __________
Mother's health during pregnancy:

___ Bleeding ___ Nausea ___ Physical or emotional trauma
___ Illnesses ___ Hypertension ___ Cigarettes, alcohol, drug consumption
___ Medications ___ Diabetes ___ Thyroid problems

BIRTH HISTORY

Term: ___Full___ Premature___ Late Length of labor: _____ Complications:______________________________
Birth city & state: ____
Birth time: ______________________ Birth weight:______________________

Did you child have any of the following problems shortly after birth?

___ Rashes ___ Birth injuries ___ Blue baby
___ Jaundice ___ Seizures ___ Cerebral palsy
___ Colic ___ Fever ___ Birth defects
___ Other: ____

Child's sleep patterns (1st year): ____
Food intolerances: ____
Breast fed: Y / N How long: ________ Formula: Y / N Type (milk, soy):______________________
Age began solids: _______ Which foods:____
Age began: Sitting _____ Crawling _____ Walking _____ Talking ______

SYMPTOMS

___ Hives ___ Burning urine ___ Bloody urine ___ Eczema
___ Cries easily ___ Bleeding gums ___ Heart murmur ___ Nervous
___ Nose bleeds ___ Vomiting spells ___ Sleep problems ___ Asthma
___ Acne ___ Anemia ___ Night sweats ___ High fevers
___ Jaundice ___ Sensitive to light ___ Chronic rash ___ Stomach aches
___ Diarrhea ___ Hearing loss ___ Easy bruising ___ Sore throats
___ Flat feet ___ No appetite ___ Body/breath odor ___ Constipation
___ Nightmares ___ Frequent colds ___ Bleeding tendency ___ Unusual fears
___ Wheezing ___ Joint pains ___ Excessive fatigue ___ Cough
___ Dizzy spells ___ Hair loss ___ Frequent urination ___ Allergies

DIET

Please describe your child's typical daily diet:
Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____
To drink: ____

PT: ______________________
PT DOB: ______________________