Pediatric Intake Form (12 Year Old and Under)

1. First Name: _____ Last Name: _____ DOB: _____

2. MRN #: _____

3. **Home Address**

Address 1 _____ Address 2 _____

City _____ State _____ Zip Code _____

4. **Contact Information**

Mobile Phone _____ Home Phone _____

Primary Email Address _____ Social Security Number _____

5. **Demographic Information**

Sex:
○ Male ○ Female

Marital Status:
○ Single ○ Married ○ Divorced ○ Widowed ○ Other

6. **Personal Information**

Height - Feet: _____ Height - Inches: _____

Weight (in pounds): _____

7. **Do you have Blue Cross Blue Shield?**

○ Yes ○ No

8. **Insurance Payer**

Insurance Payer _____

9. **Insurance Policy Information (BCBS only):**

Insurance Plan Name _____ ID/Policy Number: _____ Group Number: _____

Relationship to Patient:
○ Self ○ Spouse ○ Parent ○ Employer ○ Caregiver ○ Other

Insured's First & Last Name: _____ Insured's Date of Birth: _____

10. **Insurance Card Upload**

11. **Emergency Contact Information**

Emergency Contact Name: | Contact Phone Number: | Relationship to Patient:

12. Referral Information

Referring Physician: | Referring Patient:

How did you hear about us?

○ Word of mouth ○ Advertisement ○ Social media ○ Direct mail or email campaign ○ Event ○ Internet

Other:

Child's History

13. Have you ever received a formal diagnosis?

○ Yes ○ No

If yes, please specify:

14. Chief complaint in order of importance 1-5

	Complaint
1	
2	
3	
4	
5	

15. Pregnancy and Delivery Complications:

○ Yes ○ No

If yes, please specify:

16. Has formula ever been supplemented?

○ Yes ○ No

17. Any issues early on with the following?

☐ Sucking ☐ Latching ☐ Illnesses

☐ Eczema ☐ Collic ☐ Reflux (excessive spitting up)

☐ Other ☐ None

18. Breastfed?

○ Yes ○ No

19. Age when food was introduced?

20. Does the child consume any of the following:

- ☐ Dairy
- ☐ Gluten
- ☐ Corn
- ☐ High Sugar
- ☐ High Carbohydrates
- ☐ Artificial Dyes and Colorings
- ☐ None

21. Does the child have any adverse reactions to any of the listed above? Are there any known food sensitivities or allergies?

- ☐ Yes
- ☐ No

If yes, please specify:

_____

22. Please check any of the following that have applied throughout childhood until present:

- ☐ Eczema
- ☐ Asthma
- ☐ Allergies
- ☐ Infections
- ☐ Chronic Ear Infections
- ☐ Strep Infection
- ☐ Raised Bumps on Skin
- ☐ Reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Sinus Infections
- ☐ Other
- ☐ None

If other, please specify:

_____

23. How frequently do they have bowel movements?

_____

24. Any sleeping issues from infancy to present?

- ○ Yes
- ○ No

If yes, please specify:

_____

25. Parent Relationship:

- ☐ Married
- ☐ Divorced
- ☐ Seperated
- ☐ Live Together

26. Occupation

	Job
Father	
Mother	

27. Developmental Milestones

	Age
Sit Up	
Roll Over	
Crawl	
Walk	
Talk	

28. How many words do they speak?

- ○ 1-5
- ○ 5-20
- ○ 20-50
- ○ 50+
- ○ Non Verbal

29. Does this child make eye contact?

- ○ Yes
- ○ No

30. Do they look in a mirror?

- ○ Yes
- ○ No

31. Do they recognize or know body parts?

- ○ Yes
- ○ No

32. Do they care about their appearance? Clothes, etc?

- ○ Yes
- ○ No

33. Do they have friends?

- ○ Yes
- ○ No

34. Do they play with other kids?

- ○ Yes
- ○ No

35. Where are they in school and what grade?

	Answer
Location	
Grade	

36. Do they know the following:

- ☐ Letters
- ☐ Numbers
- ☐ Colors
- ☐ Shapes

37. Do they read at all?

- ○ Yes
- ○ No

38. Can they do math?

- ○ Yes
- ○ No

39. Can they do any of the following:

- ☐ Write
- ☐ Color
- ☐ Draw

40. Is there any learning disability in school?

- ○ Yes
- ○ No

If yes, please specify:

_____

41. What are the most difficult subjects?

_____

42. What are the child's best subjects?

43. Are there any emotional issues, tantrums, etc.?

○ Yes ○ No

If yes, please specify:

44. Are there any major sensory issues, hyper/hyposensitivities?

○ Yes ○ No

If yes, please specify:

45. Do they feel pain?

○ Yes ○ No

46. Are they a picky eater?

○ Yes ○ No

47. Do they have any food preferrences?

○ Yes ○ No

If yes, please specify:

48. What do they drink?

49. Have you eliminated any of the following from their diet?

☐ Gluten ☐ Dairy ☐ Soy
☐ Other

If other, please specify:

50. Do they have a sense of smell or taste?

○ Yes ○ No

51. Please describe their muscle tone:

○ High ○ Low ○ Within Normal Limits

52. Describe their motor skills?

☐ Gross ☐ Fine

_____ _____

53. What is their hand dominance?

○ Right ○ Left ○ Ambidextrous

54. Do they have any issues with the following?

	Yes	No
Balance		
Motion Sickness		
Afraid of High Places		
Dizziness		

55. Do they spin themselves?

○ Yes ○ No

56. Do they have any stims or tics?

○ Yes ○ No

If yes, please specify:

_____

57. Do they have any OCD behaviors?

○ Yes ○ No

If yes, please specify:

_____

58. Do they have any unusually strong skills, such as the following?

☐ Early Reading ☐ Early Speech ☐ Memorizing Songs
☐ Memory for Details ☐ Memory for Locations ☐ Other

If other, please specify:

_____

Daily Activities

59. What does the child prefer for playtime?

_____

60. How much daily screen time?

_____

61. Do they prefer to be indoors or outdoors?

_____

Familial Health History

62. Does either parent have any chronic health issues?

○ Yes ○ No

If yes, please specify:

_____

63. Is there anyone in your immediate family who has experienced the following? If yes, please select and indicate who.

	Mother	Father	Brother(s)	Sister(s)	Child 1	Child 2	Child 3	Maternal Grandmother	Maternal Grandfather	Paternal Grandfather	Paternal Grandmother	Other
Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Autoimmune Disease												
Arthritis												
Kidney Disease												
Thyroid Problems												
Seizures/Epilepsy												
Psychiatric Disorders												
Anxiety												
Depression												
Asthma												
Allergies												
Eczema												
ADHD												
Autism												
Irritable Bowel Syndrome												
Dementia												
Substance Abuse												
Genetic Disorders												
Other												

Supplements

64. Please list regularly used supplements as well as dosage and frequency for each

	Supplement	Dosage / Frequency
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

65. Have you ever had any of the following test ran?

- ☐ Blood Test
- ☐ MRI
- ☐ Gentetic
- ☐ Stool Testing
- ☐ EEG
- ☐ Allergy
- ☐ Other

If other, please specify:

_____

66. Has the child received any other treatment? Were they beneficial? Did you notice any improvement and which was the most effective?

_____

Parent / Legal Guardian

_____

Signature