Pediatric Intake Form

Our practice is dedicated to providing the best possible care for your child. In order for us to serve you better, please take a few minutes to answer the following questions. Your answers will be kept strictly confidential as part of your child's medical record. Ongoing evaluations of our care may involve chart reviews by qualified persons, but neither your name nor your child's name will ever appear in any reports.

Child's Name:____

Today's Date:____

Circle either the word or the letter for your answer where appropriate. Fill in answers where space is provided.

Are you the child's

A. Mother B. Father C. Grandparent D. Foster Parent

E. Other relative F. Other G. Self (Are you the patient?)

How many times have you moved in the last year? _______times

Where is the child living now?

A. House or apartment with family B. House or apartment with relative or friends

C. Shelter D. Other

Besides you, does anyone else take care of the child? Yes No

If yes, who? ______________________________

Has the child received health care elsewhere? Yes No

If yes, what? ______________________________

Has the child received any immunizations? Yes No

Which ones?______________________________

Where?__________________________________

Has the child ever been hospitalized? Yes No

When?__________________________________

Where?__________________________________

Why?___________________________________

How would you rate this child's health in general?

A. Excellent B. Good C. Fair D. Poor

Do you have concerns about your child's behavior or development? Yes No

If yes, what? ____

What are your main concerns about your child?

____

____

How old are you? _________ years old

Are you

A. Single B. Married C. Separated D. Divorced E. Other

What is the highest grade you completed?

1 2 3 4 5 6 7 8 9 10 11 12 (High School/GED) Some college or vocational school

College graduate Postgraduate

Family Medical History

Do the child's mother, father, or grandparents have any of the following? If yes, who?

Yes	No	High Blood Pressure ____
Yes	No	Diabetes ____
Yes	No	Lung Problems (asthma) _____________________________________
Yes	No	Heart Problems____
Yes	No	Miscarriages ____
Yes	No	Learning Problems____
Yes	No	Nerve Problems ____
Yes	No	Mental illness (depression) _________________________________
Yes	No	Drinking Problems____
Yes	No	Drug Problems ____
Yes	No	Other ____

Family Health Habits

How often does your child use a seatbelt (carseat)?
A. Never B. Rarely C. Sometimes D. Often E. Always

Does your child ride a bicycle? Yes No
If yes, how often does he/she use a helmet?
A. Never B. Rarely C. Sometimes D. Often E. Always

Do you feel that you live in a safe place? Yes No

In the past year, have you ever felt threatened in your home? Yes No

In the past year, has your partner or other family member pushed you, punched you, kicked you, hit you, or threatened to hurt you? Yes No

What kind of guns are in your home?
A. Handgun B. Shotgun C. Rifle D. Other_____ E. None
If you have a gun at home, is it locked up? N/A Yes No

Does anyone in your household smoke? Yes No
If yes, how many cigarettes do you smoke per day?
_____________cigarettes per day