INTAKE FORM



NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_

Reason for your Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medication Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had any **major illnesses** since your last office visit? □ No □ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had any **surgeries** since your last office visit? □ No □ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had any **hospitalizations** since your last office visit? □ No □ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe any other changes to your family history or social history here: □ None

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications your child is currently or recently on including over the counter and prescription: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did they finish the full prescription? □ Yes □ No If No, when did they stop it?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Briefly, describe your child’s current symptoms:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS:** If your child is experiencing or has recently experienced any of the following, please mark below:

Office Use Only:

B/P \_\_\_\_\_\_\_\_\_\_ P \_\_\_\_\_\_\_\_\_ R \_\_\_\_\_\_\_\_\_ Pulse Ox \_\_\_\_\_\_\_\_\_\_ Temp \_\_\_\_\_\_\_\_\_\_ HT \_\_\_\_\_\_\_\_\_ WT \_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **General**□ Fever: \_\_\_\_\_\_\_\_\_\_\_°F□ Weight loss□ Weigh gain□ Fatigue**Skin**□ Rash□ Swelling□ Dryness□ Itching□ Eczema□ Color change□ Infection□ Change in hair□ Change in nails**Blood**□ Abnormal blood test□ Bleed easily□ Bruise easily□ Anemia**Head**□ Headache□ Head Injury**Neck**□ Swollen nodes□ Stiffness□ Pain**Eyes**□ Poor vision□ Blurry vision□ Sensitive to light□ Pain□ Redness□ Discharge□ Excess tearing□ Double vision□ Infections | **Ears**□ Ear Pain□ Poor hearing□ Ringing in ears□ Dizziness□ Infection□ Discharge□ Excess ear wax**Noses/Sinuses**□ Runny Nose□ Nasal stuffiness□ Allergies□ Nosebleeds□ Sinus trouble□ Color\_\_\_\_\_\_\_\_\_\_\_\_\_**Mouth/Throat**□ Cavities□ Cold sores□ Hoarseness□ Sore throat□ Blisters**Lungs**□ Cough□ Wheezing□ Shortness of breath□ Difficulty breathing**Heart**□ Heart murmur□ Palpitations**Musculoskeletal**□ Joint pains□ Stiffness□ Backache□ Muscle pain or cramps | **Urinary**□ Pain□ Blood in urine□ Urgency□ Incontinence□ Bed wetting□ Infections□ Frequency□ Urinating less**Endocrine**□ Heat intolerance□ Cold intolerance□ Excessive sweating□ Excessive thirst□ Excessive hunger□ Excessive urination**Circulation**□ Leg cramps□ Cold extremities**Digestion**□ Excess □ Belching □ Bloating □ Passing Gas□ Trouble swallowing□ Heartburn□ NauseaAppetite □ increased □ Decreased□ Vomiting □ with blood□ Abdominal pain□ Constipation□ Diarrhea□ Blood in stool□ Change in bowel habitsStools □ pale □ black | **Nervous System**□ Fainting□ Blackouts□ Seizures□ Paralysis□ Local weakness□ Numbness□ Tingling□ Tremors□ Memory**Mind**□ Nervousness□ Lack of concentration□ Memory issues**Emotions**□ Mood swings□ Depression□ Excess anger□ Sadness□ Frustration□ Mania□ difficulty feeling or expressing emotions**Please list other:**­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |