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  □ Nausea  Appetite □ increased  □ Decreased  □ Vomiting  □ with blood  □ Abdominal pain  □ Constipation  □ Diarrhea  □ Blood in stool  □ Change in bowel habits  Stools □ 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:**  ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |