HEALTH HAVEN

PEDIATRIC INTAKE FORM

Please complete as much as possible. Your information is kept confidential and is used to provide safe, appropriate care.

PATIENT INFORMATION

Child's Full Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____ City/State/Zip: _____

Parent/Guardian Name: _____ Phone Number: _____

Parent/Guardian Name: _____ Phone Number: _____

Email Address: _____

Pediatrician Name & Clinic: _____

Who/where may we thank for referring you to our office?: _____

REASON FOR TODAY'S VISIT

What is the primary reason for bringing your child in today? _____

_____

When did this issue first begin? _____

Have you seen anyone else for this condition? ☐ No ☐ Yes If yes, please explain:

_____

BIRTH HISTORY & DELIVERY

Type of delivery: ☐ Vaginal ☐ Breech ☐ C-Section Planned ☐ C-Section Emergency

Interventions Used: ☐ None ☐ Forceps ☐ Vacuum Extraction ☐ Induced

Location of Birth: ☐ Hospital ☐ Birth Center ☐ Home

Birth Weight: _____ Birth Length: _____

Were there any complications during pregnancy or delivery? _____

_____

Congenital Anomalies/Defects: _____

FEEDING & DEVELOPMENTAL HISTORY

Feeding Method: □ Breast Milk □ Formula □ Both _____

Does your child experience any of the following? (Check all that apply)

□ Latching difficulties □ Colic or excessive crying □ Prefers turning head to one side

□ Frequent spitting up □ Constipation or gas □ Allergic reactions / Skin rashes

Number of hours of sleep per night: _____ Quality of sleep: □ Good □ Fair □ Poor

Is your child meeting their developmental milestones (sitting, crawling, walking on time?

□ Yes □ No If no, please detail: _____

HEALTH HISTORY

Medication, Vitamin, Supplement	Dose / Frequency	Reason / Notes

Procedure / Surgery	Approx. Date	Notes

Accident / Injury / Hospitalization	Approx. Date	Notes

Childhood diseases:

□ Cancer	□ Diabetes	□ Diabetes	□ Seizures/Epilepsy
□ Chicken Pox	□ Mumps	□ Measles	□ Rubella
□ Rubeola	□ Whooping Cough		

Please check any of the following conditions your child has suffered:

□ Headaches	□ Ear Infections	□ Bed wetting	□ Diarrhea
□ Scoliosis	□ Torticollis	□ Asthma	□ Upset Stomach

Any other health concerns to note? _____

_____

List any known allergies: _____

PATIENT ACKNOWLEDGMENT

I certify that the information I have provided on this form is true and complete to the best of my knowledge. I understand that I should inform the doctor of any changes in health, medications, or medical history.

Parent/Guardian Signature: _____ **Date:** _____

Thank you for taking the time to fill out this form thoroughly and for choosing Health Haven!