

Pediatric Initial Intake

Dr. Katie Swedrock, ND

Name: _____ Date of Birth: _____

Sex: M F Grade in School: _____

Mother's Name: _____

Father's Name: _____

Are both Parents actively involved in child's life: Yes No

Concerns in order of importance:

1. _____
2. _____
3. _____
4. _____

Names of Pediatricians seen: _____

Date of Last:

Doctor's visit: _____ Blood work: _____ Dental Exam: _____

Eye Exam: _____

Current Medications and supplements (include dosage): _____

Previous Hospitalizations and surgeries (include date): _____

Allergies (food/medicine): _____

Vaccination History:

Please indicate if Yes (Y), No (N) or had Some (S):

MMR: Y N S Hemophilis (Hib): Y N S DPT: Y N S

Polio: Y N S Chicken Pox: Y N S Hepatitis B: Y N S

Other Vaccinations: _____

Previous Medical History:

Child Breast Fed: Y N For how long: _____ Age when Formula: _____

Type of Formula: _____ When were they put on solid food: _____

Walk: _____ Talk: _____ Teeth: _____

Pregnancy History:

Mother's age at conception: _____ Previous Pregnancies: Y N

Alcohol: Y N Smoking: Y N Recreational Drugs: Y N

Gestational Diabetes: Y N Preeclampsia: Y N Vaginal Birth: Y N
 Length of Labor: _____
 Complications of Pregnancy: _____
 Child's Health at Birth: _____

Family History:

Family Member	Age if Living	Age of Death	Reason of Death
Mother			
Father			
M. Grandmother			
M. Grandfather			
P. Grandmother			
P. Grandfather			
Siblings			

Disease	Family Member
Heart attack/stroke	
Cancer (include type)	
Mental Illness	
Heart Disease	
High Blood Pressure	
Osteoporosis	
Asthma/allergies	
Autoimmune(RA,Lupus,etc)	
Diabetes	

Review of Systems:

Indicate yes (Y), No (N), or passed (P):

Jaundice	Y	N	P	Cradle Cap	Y	N	P	Eczema/Psoriasis	Y	N	P
Diarrhea	Y	N	P	Constipation	Y	N	P	Finicky Eater	Y	N	P
Poor teeth	Y	N	P	Chronic Sniffles	Y	N	P	Bad Feet Odor	Y	N	P
Very Sweaty	Y	N	P	Growing Pains	Y	N	P	Hyperactivity	Y	N	P
Colic	Y	N	P	Bed wetting	Y	N	P	Early Puberty	Y	N	P
Anemia	Y	N	P	Tantrums	Y	N	P	Stomach Aches	Y	N	P
Asthma	Y	N	P	Disobedient	Y	N	P	Abnormal Vision	Y	N	P
Warts	Y	N	P	Fears/phobia	Y	N	P	Abnormal Hearing	Y	N	P
Nightmares	Y	N	P	Diaper Rash	Y	N	P	Abnormal Speech	Y	N	P
Ear Infections	Y	N	P	Strept Throat	Y	N	P	Learning Problems	Y	N	P

Approximately how many times has the child been on Antibiotics: _____

