Eric Udell, ND *1250 E Baseline Rd., Suite 104* ***Laurinda Kwan, ND***
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Mona Morstein, N

Pediatric Intake Form

Today's Date_____/_____/

Patient Name_____ DOB_____ Age_____ Sex: ☐Male ☐Female

Address_____ City_____ State_____ Zip

Parent or Guardian Contact Information

Name_____ Relationship to Child

(☐check box if address is same as above)
Address_____ City_____ State_____ Zip

Home Phone_____ Cell or Alternate Phone_____ E-mail

Parents are: ☐Married ☐Separated ☐Divorced ☐Common Law ☐Other:

How did you hear about us?

Emergency Contact

Name_____ Relationship to Child

Phone_____ Cell or Alternate Phone

Pediatrician

Name_____ Phone

Address_____ City_____ State_____ Zip

Health Concerns

Please list health concerns in order from most bothersome to least bothersome. Please include Mental, Emotional, and Physical concerns.

1)_____ Length of Time
2)_____ Length of Time
3)_____ Length of Time
4)_____ Length of Time

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Birth History

Prenatal

Previous Preg.(#)_____ Previous Births(#)
At time of conception:
Mother's Age
Father's Age
Mother's Pregnancy History:
Please check all that apply.
☐Nausea/vomiting
☐High Blood Pressure

☐Anemia
☐Preeclampsia

☐Gestational Diabetes
☐Thyroid Condition

☐Bleeding
☐Physical Trauma

☐Infection
☐Emotional Stress

☐Coffee
☐Smoking

☐Recreational Drugs
☐Alcohol

☐Prescription Medication (please list)

Did you take a prenatal vitamin:☐Yes ☐No

Birth

Did baby deliver on time?
(If No, + weeks =_____, or – weeks =_____).
Length of Labor
Vaginal Birth or C-Section
Babies birthweight (lbs)_____ Length (in.)
Were there any birth complications?

Hospitalizations, Surgeries, and Major Illnesses

Condition or Procedure Date
1)
2)
3)
4)

Vaccination History

Please check all that apply.
☐HepB ☐DTP ☐Hib ☐Polio ☐MMR
☐Varicella ☐Other
Any reactions or complications from vaccinations?

Medications

Please list all prescription and over-the-counter medications child is currently taking.

Supplements

Please list all supplements child is currently taking, including brand names.

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Medication	Dosage	Supplement	Dosage
1)		1)	
2)		2)	
3)		3)	
4)		4)	

Health History

Any known allergies to foods, medications, environmental or other allergy? Please describe.

_____

	Now	Past
Asthma	☐	☐
Gastric Reflux	☐	☐
Chicken Pox	☐	☐
Coughing/Wheezing	☐	☐
Colic/Gas	☐	☐
Mononucleosis	☐	☐

Eczema	☐	☐
Teething Difficulty	☐	☐
Mumps	☐	☐
Hives	☐	☐
Thrush	☐	☐
Rubella	☐	☐
Chronic Sniffles/Runny Nose	☐	☐
Cradle Cap	☐	☐
Pneumonia	☐	☐
Frequent Colds	☐	☐
Psoriasis	☐	☐
Whooping Cough	☐	☐
Strep Throat/Tonsillitis	☐	☐
Diaper rash	☐	☐
Jaundice	☐	☐

☐ ☐ Anemia

☐ ☐ Stomach Aches

☐ ☐ Dental Cavities

☐ ☐ Cold Sores

☐ ☐ Diarrhea

☐ ☐ Epilepsy/Seizures

☐ ☐ Headaches

☐ ☐ Constipation

☐ ☐ Hyperactivity

☐ ☐ Ear Infections
(# times):

☐ ☐ Bed-wetting

☐ ☐ Anxiety

☐ ☐ Very Sweaty Baby/Child

☐ ☐ Urinary Tract Infxn

☐

☐

Nightmares

Hearing Test Normal: ☐Yes ☐No ☐Not Tested
Vision Test Normal: ☐Yes ☐No ☐Not Tested

Speech Difficulty: ☐Yes ☐No ☐Past
Learning Difficulty: ☐Yes ☐No ☐Past

How many times has the child taken antibiotics?

General

Was child breastfed?
If yes, for how long?_____ If no, what formula?
When was solid food introduced?

When did the following milestones occur:
Rolling over_____ First tooth_____ Sitting_____ Walking _____ Talking_____ Dressed self

Family History

Mother
Father
Siblings
Grandparents

Allergies

Asthma

Eczema

Diabetes

Cancer

Cardiovascular Disease

Obesity

Tuberculosis

Mental Illness

Other: