PIMRI Pediatrics

INFANT/CHILD/ADOLESCENT/TEEN INTAKE FORM

PATIENT INFORMATION			
Patient's Last name:	First:		Suffix:
Date of Birth:	Assigned Sex: ☐ M ☐ F	Gender Identity:	
Patient's address:			
City:	State:	ZIP Code:	
Grownup's name:			
Lives with patient? ☐ Yes ☐ No	Occupation:		
Telephone: ( ) -	E-mail Address:		
Street address (IF different from patient)			
City:	State:	ZIP Code:	
Grownup's name:			
Lives with patient? ☐ Yes ☐ No	Occupation:		
Telephone: ( ) -	E-mail Address:		
Street address (IF different from patient)			
City:	State:	ZIP Code:	
How did you become aware of Dr. Nic Peters or PIMRI Pediatrics?			
Pharmacy Name:	Phone Number: ( ) -		
Address or Cross streets:			

WHAT ARE THE CONCERNS FOR YOUR CHILD?

What health problems or concerns do you wish to address at this time? ☐ None	
	1.
	2.
	3.
	4.
	5.
	6.
	7.
	8.
	9.
	10.

Please list all medical, naturopathic, holistic, and mental health specialists who currently care for your child:		
Name:		Name:
Sub-specialty:		Sub-specialty:
Address:		Address:
Telephone:		Telephone:
Fax:		Fax:
Name:		Name:
Sub-specialty:		Sub-specialty:
Address:		Address:
Telephone:		Telephone:
Fax:		Fax:

MEDICATIONS/SUPPLEMENTS/HERBS/VITAMINS/HOMEOPATHIC REMEDIES CURRENTLY BEING USED BY THE PATIENT

ALLERGIES

☐ **No known allergies**

To Medications, Foods, Environment, etc.:

PAST MEDICAL HISTORY

PREGNANCY/LABOR/DELIVERY ☐ Limited: Child is adopted

Full term: ☐ Yes (37+ weeks) ☐ No If No, gestational age at delivery: _____ weeks

☐ vaginal delivery ☐ C-section

Measurements (IF known): Birth weight:_____

Birth length:_____ Head circumference:_____

Complications after birth? ☐ Yes ☐ No

Was a NICU stay required? ☐ Yes ☐ No

For Newborns Only:

Hepatitis B Vaccination given at birth?: ☐Yes ☐ No

Vitamin K given at birth? ☐Yes ☐ No

Eye prophylaxis given at birth? ☐Yes ☐ No

Please describe any "Yes" Answers or provide additional pregnancy/birth information:

IMMUNIZATIONS

Is your child up to date with immunizations? ☐Yes ☐No ☐Unsure

Do you feel immunizations have had an adverse impact on your child's health? ☐Yes ☐No If Yes, describe:

_____

_____

Has your child had any, even slight complication from a vaccine given (i.e. extremely fussy for more than 48 hours, excessive crying that was out of the norm, high fevers for more than 24 hours, extreme swelling at the site or even a few inches from the injection site, changes to the skin immediately or a few days after the vaccine, hospitalization, frequent urgent care or office visit) ☐Yes ☐No

ADDITIONAL MEDICAL HISTORY

Hospitalizations, Surgeries, Procedures, Major illnesses, etc. including dates:

DEVELOPMENTAL HISTORY

Please describe any developmental issues (speech/communication, motor, social, milestones, etc.) your child has, may have, or had in the past:

EDUCATION

School name: _____ Current grade level _____

☐ public ☐private/parochial ☐charter ☐home school ☐co-op

Any Past or Present special educational services ☐Yes ☐No

SLEEP/REST

Does your child have trouble falling asleep? ☐Yes ☐No

Does your child snore? ☐Yes ☐No

NUTRITION

Describe your child's diet: _____

_____

Does your child follow a special diet or nutritional program? ☐Yes ☐No. If Yes, describe: _____

_____

Food cravings? ☐ Yes ☐ No If yes, which food(s)? _____

_____

BIOLOGICAL FAMILY HISTORY

☐ Limited or unknown: Child is adopted

Please list health conditions such as: arthritis, asthma, alcoholism, Alzheimer's, autism, cancer (type and age at diagnosis), depression, developmental problems, diabetes, drug addiction, eating disorders, genetic disorders, glaucoma, heart disease/Heart attack, infertility, learning disability, mental illness, migraines, neurologic illness, obesity, osteoporosis, stroke, seizures, suicide, etc.

Family Member	Healthy?	Medical problems
Mother	☐	☐
Father	☐	☐
Siblings (names)		
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
Maternal grandmother (mother's mother)	☐	☐
Maternal grandfather (mother's father)	☐	☐
Paternal grandmother (father's mother)	☐	☐
Paternal grandfather (father's father)	☐	☐

Other family notable medical history (i.e. Grandparents' siblings, aunts/uncles, cousins, etc.):

FAMILY DYNAMICS

Please list ALL persons residing within the home (parents, siblings, cousins, grandparents, nieces, nephews,etc):

Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age

Pets in the home? ☐Dog(s) ☐Cat(s) ☐Reptile(s) ☐Rodent(s) ☐Other: _____

Is your child adopted? : ☐ Yes ☐ No Date of adoption:

Are parental caretakers biological? ☐ Yes ☐ No
Any history of separation/ divorce? ☐ Yes ☐ No
Is either biological parent deceased? ☐ Yes ☐ No

Please list any additional issues in the home you would like us to be aware of: