# Child Intake Form

Date:_____/_____/__________

## PATIENT INFORMATION

Child's Name: Gender:

Date of Birth (mm/dd/yyyy): / / Child's Age:

Parent/Guardian's Name: Zip:

Address: City: Zip:

Phone (primary): (secondary):

Child's Pediatrician/Doctor: MD Tel:

Other Healthcare Providers:

How did you hear about Wildwood:

*Optimal health is only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. Your time, thoughtfulness and honesty in completing this confidential overview will greatly assist our understanding of your healthcare needs and desires.*

## HEALTH INFORMATION

What is your main health concern about your child's health?________________________________

Has a diagnosis been made regarding your child's main health concern? Yes / No

Who made the diagnosis?________________________________

How has this condition been treated until now? ________________________________

What else would you like to see changed in you child's health?

1. ________________________________
2. ________________________________
3. ________________________________

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## CHILD'S HEALTH HISTORY

Please list all **current** medications and supplements your child is on. Indicate how long he/she has been taking it.

| Medication/Supplement | How long? | Medication/Supplement | How long? |
|---|---|---|---|
| 1. | | 5. | |
| 2. | | 6. | |
| 3. | | 7. | |
| 4. | | 8. | |

Please list all **past** medications your child has taken.

| Medication | Illness | Adverse reaction? |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5 | | |

How many times has your child been treated with antibiotics? ______________________

Please indicate the childhood diseases that you child has had. Include whether it was **mild**, **average**, or **severe**.

| Disease | Age | Severity | Disease | Age | Severity |
|---|---|---|---|---|---|
| Asthma | | | Pertussis (Whooping Cough) | | |
| Chickenpox | | | Pneumonia | | |
| Eczema | | | Rheumatic Fever | | |
| Fifth's Disease | | | Roseola | | |
| Frequent Ear Infections | | | Rubella (German Measles) | | |
| Impetigo | | | Rubeola (Measles) | | |
| Mononucleosis | | | Scarlet Fever | | |
| Mumps | | | Strep Throat | | |

What vaccinations has your child had?

| Vaccination | Age | Adverse reaction? |
|---|---|---|
| Chickenpox | | |
| DPT | | |
| Flu Shot | | |
| Hepatitis B | | |
| Hemophilus Influenza B | | |
| MMR | | |
| Polio | | |
| Other: | | |

Does your child have any known food allergies / intolerances? ________________________________________________

________________________________________________

Does your child have any known environmental allergies? ________________________________________________

________________________________________________

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## FAMILY HISTORY

Please indicate whether any of the child's family members have, or have had the following:

| Condition | Relative | Condition | Relative |
|---|---|---|---|
| Alcoholism | | Diabetes | |
| Allergies | | Drug Abuse | |
| Alzheimer's Disease | | Heart Disease | |
| Arthritis | | High Blood Pressure | |
| Asthma | | Kidney Disease | |
| Cancer (Indicate Type) | | Osteoporosis | |
| Depression | | Stroke | |
| Other Mental Illness: | | Suicide | |

Does the child's mother or father have a chronic illness? What is their general state of health?

Mother: ______________________________

______________________________

Father: ______________________________

______________________________

*Thank you very much for taking the time to complete this form.*
*It will greatly assist in the formulation of a treatment protocol specific to your child.*

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