Intake Form (New Patient, Well Child Checks)

Today's Date:_____ Patient Name:_____
Date of Birth:_____ Current Age:_____
Name of Person Completing Form:_____ Relationship: _____

Patient Birth History (If under the age of 6 years old):

Birth Weight:_____
Delivering Hospital:_____ Length of Pregnancy:_____ weeks
Type of Delivery: □ Vaginal □ C-Section
Complications of Pregnancy, Labor, or Delivery: □ No □ Yes, List _____
Baby went to: □ Well Baby Nursery □NICU Length of Stay_____
Problems in Hospital? □ No □ Yes, List_____

Mother's Age at Delivery:_____ Previous Pregnancies: Full Term:_____
Premature: _____ Miscarriages/Abortions:_____
Current Diet: □ Breastfeeding □ Formula & Type _____ □ Both
Frequency:_____ How many ounces?_____
Mother Substance Use with Pregnancy:
□ Alcohol □ Cigarettes/E-Cigarettes/Vaping □ Marijuana □ Cocaine □ Heroin
□ Methamphetamine □ Caffeine □ Opioids □ Hallucinogens □ Other
□ Prescription Medications (during pregnancy and if breastfed): _____
_____
Developmental Difficulties: _____
_____

Patient Past Medical History:

Allergies:
... Medications: _____
... Dietary: _____
... Environment/Other: _____
Medical History: _____
_____
_____
Surgical History:_____
_____
_____
_____
History of Abuse □ Physical □ Verbal/Mental □ Sexual □ Domestic Violence Exposure □ Other
History of Trauma □ No □ Yes (Type: _____)
Other: _____
_____
Current Medications, Supplements, Vitamins:_____
_____
_____
Immunizations □ Up To Date □ Desire vaccinations if due □ Does not vaccinate □ Unknown

Additional information that you would like to share to help us provide the best care for your child:

_____
_____
_____

Family History:

Condition	Yes	No	Relationship	Condition	Yes	No	Relationship
Arthritis	☐	☐	_____	Elevated Cholesterol	☐	☐	_____
Asthma	☐	☐	_____	Elevated Blood Pressure (Hypertension)	☐	☐	_____
Autism	☐	☐	_____	Genetic Disorder	☐	☐	_____
Blood Disorder	☐	☐	_____	Hearing Difficulties	☐	☐	_____
Celiac Disease	☐	☐	_____	Heart Disease/Disorders	☐	☐	_____
Digestive Disorder	☐	☐	_____	Kidney Disease	☐	☐	_____
Eczema	☐	☐	_____	Seizures	☐	☐	_____
Thyroid	☐	☐	_____	Sickle Cell	☐	☐	_____
Vision	☐	☐	_____	Orthopedic (Bone)	☐	☐	_____
Tuberculosis	☐	☐	_____	Bipolar Disorder	☐	☐	_____
Anxiety	☐	☐	_____	Schizophrenia	☐	☐	_____
Depression	☐	☐	_____	Suicide	☐	☐	_____
Substance Abuse	☐	☐	_____	Other Mental Health	☐	☐	_____
Alcohol Abuse	☐	☐	_____	Lung Cancer	☐	☐	_____
Breast Cancer	☐	☐	_____	Other Cancer	☐	☐	_____
Skin Cancer	☐	☐	_____				

Please provide additional information for any responses marked "yes": _____

_____

_____

Patient Social History:

Patient lives with: _____

_____

☐ House ☐ Apartment ☐ Other Pets ☐ Yes ☐ No Type: _____

Biological Parents ☐ Married ☐ Divorced ☐ Separated ☐ Other

If two separate households, the parenting time share is _____

_____

Guardian(s) Occupations _____

_____

In the home ☐ Guns (☐ Secured ☐ Unsecured) ☐ Not Applicable

Secondhand Smoke Exposure ☐ Yes (☐ In home ☐ In car ☐ Outside) ☐ None

Car Safety ☐ Seatbelt ☐ Rear Facing Car Seat ☐ Forward Facing Car Seat ☐ Booster Seat ☐ None

Safety ☐ Wears a helmet ☐ Electronics < 2 hours/day

Describe Patient Physical Activities _____

Describe Patient Nutrition: _____

How Does Patient Do With Peers (ex. Bullying): _____

Patient School: _____ Grade: _____

School Performance: _____

Patient Employment: _____ Hours/Week: _____ ☐ Not Applicable