

952.881.2800 office
 5143 w 98th street
 bloomington, mn 55437
 wellbloomington.com

Pediatric Intake Form

Case History for Children 12 & Under (page 1 of 2)

Child's Name: _____ Date of Birth: ____/____/____

Mother's Name: _____

Father's Name: _____

Health Objectives

Chief health concern? (describe in detail) _____

Other health concerns? _____

As the parent or guardian, what strategies could you employ to help ensure the future health of your child?

Prenatal History

As many childhood and adult health problems arise from pregnancy or through events occurring during labor and delivery, the following information is vital in determining the onset of illness or injury.

Problems during pregnancy? _____

Was there *alcohol, smoking, illicit, prescription or over-the-counter drug use* during pregnancy? **Y / N / Unsure**

If **Yes**, please list: _____

Circle type of birth: **Vaginal / Forceps / Vacuum / Breech / Cesarean** - **Planned** or **Emergency**

Problems during labor/delivery? _____

Was there medication or anesthesia used during labor or delivery? **Y / N / Unsure**

If **Yes**, please list: _____

Did the provider assist delivery with their hands? **Y / N / Unsure**

If **Yes**, did he/she turn or pull the baby's head? **Y / N / Unsure**

Was there any visible injury to the baby after delivery? **Y / N / Unsure**

If **Yes**, please describe: _____

Weeks Gestation at Birth: _____ Birth Weight: _____ Birth Length: _____

Developmental History

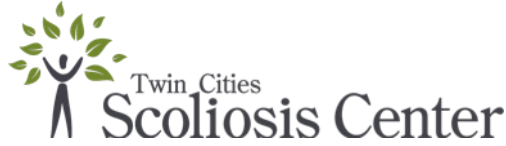
At what age was your child able to respond to:

Sound: _____ Visual Stimuli: _____ Hold Head Up: _____ Sit Up: _____

Cross Crawl: _____ Stand Alone: _____ Walk Alone: _____ First Words: _____

Are you concerned about any developmental delays? **Y / N**

If **Yes**, please list: _____



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Feeding History

Was your child breast fed? **Y / N** If **Yes**, how long? _____ Was your child formula fed? **Y / N** If **Yes**, how long? _____
 If formula fed, list type(s) of formula used and reason for each: _____

Introduced to solids at: _____ months. Cows milk at: _____ months.
 Does your child have food or juice allergies or intolerances? **Y / N** If **Yes**, please list: _____

Please briefly describe your child's current diet: _____
 How could their diet be changed for the better? _____

Health History

*According to the International Safety Council, 50% of children have fallen onto their heads during their 1st year of life.
 Another study reveals ¼ million children are injured on playgrounds annually.*

Has your child experienced any such jolts, falls, or traumas? **Y / N** If **Yes**, please describe: _____

Please check any of the following conditions your child has suffered from past and present:

- | | | | | |
|---|---|--|---------------------------------------|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Rubeola |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Colds | <input type="checkbox"/> Fevers | <input type="checkbox"/> Mumps | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> ADHD / ADD | <input type="checkbox"/> Colic | <input type="checkbox"/> Growing Pains | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Headaches | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Sleeping Disorders |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Irritability | <input type="checkbox"/> Rashes | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Measles | <input type="checkbox"/> Rubella | <input type="checkbox"/> Other: _____ |

Please list all past and present athletic activities your child has participated in: _____

Has your child ever been involved in an automobile accident? **Y / N** If **Yes**, please list: _____

Has your child ever been seen on an emergency basis? **Y / N** If **Yes**, please list: _____

List any other traumas, surgeries and/or hospitalizations: _____

Please list all past and present drug treatments your child has received (Prescription & over-the-counter)
 and reasons for each: _____

Does your child spend prolonged time sitting? **Y / N** Approximate hours a day: _____

Has your child been screened by a doctor skilled in the detection of scoliosis? **Y / N / Unsure**

Was your child vaccinated? **Y / N** If **Yes**: Full Schedule / Partial

Did your child experience any immediate or delayed adverse reactions? **Y / N / Unsure**

If **Yes**, please describe: _____

On a scale of **0 - 10** describe your child's stress level: (**0 = None / 10 = Extreme**)

On a scale of **0 - 10** describe your child's: (**0 = Poor / 10 = Excellent**)

Exercise: _____ Sleep: _____ Diet: _____ Emotional Health: _____ Overall Health: _____