ELIXIA
wellness group

PEDIATRIC INTAKE FORM (6-12 years)

HEALTH HISTORY QUESTIONNAIRE

What are your child's most important health problems? List as many as you can in order of importance.

1)_____

2)_____

3)_____

4)_____

Does your child have a contagious disease at this time? Y N

If yes, what? _____

Previous Illnesses

Rheumatic fever	Y N	German measles	Y N
Chicken pox	Y N	Measles	Y N
Tonsillitis	Y N	approx. number _____	
Ear infections	Y N	approx. number _____	
Other	Y N	list _____	

Has your child had any of the following tests?	When	Where
Electroencephalogram (EEG)	_____	_____
Psychological evaluation	_____	_____
Hearing tests	_____	_____
Speech/Language tests	_____	_____

Hospitalizations/ Surgeries/ Injuries

What hospitalizations, surgeries or injuries has your child had?

_____

_____

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Immunizations

Polio	Y	N	Pertussis	Y	N
Tetanus shot	Y	N	Diphtheria	Y	N
Measles/Mumps/Rubella	Y	N	Influenza	Y	N
Any adverse reactions?	Y	N	If yes, what ? _____		

Allergies

Is your child hypersensitive or allergic to:

Any drugs?_____

Any foods? _____

Any environmentals?_____

Breast fed? _____ how long? _____Formula? _____ milk / soy _____

Typical Food Intake

Breakfast:_____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Please list **any** prescription medications, over the counter medications, vitamins or other supplements your child is taking.

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

REVIEW OF SYSTEMS

Y = a condition now **P** = a condition in the past **N** = never had

MENTAL/ EMOTIONAL

Mood Swings	Y	P	N	Anxiety/nervousness	Y	P	N
Irritability	Y	P	N	Cries easily	Y	P	N
Hyperactivity	Y	P	N	Unusual fears	Y	P	N
Introvert/extrovert	Y	P	N	Sleep problems	Y	P	N
Motion/car sickness	Y	P	N	Nightmares	Y	P	N

ENDOCRINE

Heat/cold intolerance	Y	P	N	Fatigue	Y	P	N
Excessive thirst	Y	P	N	Excessive hunger	Y	P	N
Low blood sugar	Y	P	N	High blood sugar	Y	P	N

SKIN

Rashes	Y	P	N	Eczema, Hives	Y	P	N
Acne, Boils	Y	P	N	Itching	Y	P	N

HEAD

Headaches	Y	P	N	Head Injury	Y	P	N
Dizzy spells	Y	P	N	High fevers	Y	P	N

EYES

Glasses or contacts	Y	P	N	Tearing or dryness	Y	P	N
Eye pain/strain	Y	P	N				

EARS

Earaches	Y	P	N	Impaired hearing	Y	P	N

NOSE AND SINUSES

Frequent colds	Y	P	N	Nose Bleeds	Y	P	N
Stuffiness	Y	P	N	Hayfever	Y	P	N
Sinus problems	Y	P	N	Loss of smell	Y	P	N

MOUTH AND THROAT

Frequent sore throat	Y	P	N	Canker sores	Y	P	N
Breath odor	Y	P	N				

RESPIRATORY

Cough	Y	P	N	Wheezing	Y	P	N
Asthma	Y	P	N	Bronchitis	Y	P	N

CARDIOVASCULAR

Heart disease	Y	P	N	Murmurs	Y	P	N

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UNINARY

Frequent urination	Y	P	N	Bed wetting	Y	P	N

GASTROINTESTINAL

Belching/passing gas	Y	P	N	Stomach aches	Y	P	N
Constipation	Y	P	N	Diarrhea	Y	P	N
Bowel Movements	How often _____						

MUSCULOSKELETAL

Joint pain/stiffness	Y	P	N	Muscle spasms/cramps	Y	P	N
Broken bones	Y	P	N				

BLOOD/PERIPHERAL VASCULAR

Anemia	Y	P	N	Easy bleeding/bruising	Y	P	N

Is there any information about your child's health that you would like to add?

Welcome! We are honored to be of service for you and your child!