ELIXIA
wellness group

Pediatric Intake Form (Birth to 5 years)

Reason for referral or presenting problems_____

_____

MEDICATIONS	Now	Past		Now	Past
Aspirin	____	____	Antibiotics	____	____
Tylenol	____	____	Anti-histamine	____	____
Decongestant	____	____	Other	____	____
Ibuprofen	____	____			

Allergies to medicines _____

MEDICAL HISTORY

____ Chicken Pox ____ Scarlet fever ____Tonsillitis, approx. no. _____

____ Measles ____ Pneumonia ____ Ear Infections, no._____

____ Mumps ____ Frequent colds

____ Rubella ____ Rheumatic Fever Other _____

Has your child had any of the following tests? **When** **Where Results**

Electroencephalogram _____

Psychological evaluation _____

Hearing _____

Speech/Language _____

Injuries/Surgeries/Hospitalizations _____

_____

IMMUNIZATIONS

____ Measles ____ Polio ____ MMR ____ Smallpox
____ Mumps ____ DPT ____ Tetanus ____ Influenza
____ Diphtheria

Other _____

Any adverse reactions? Y N What? _____

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FAMILY HISTORY

____ Heart disease ____ Diabetes ____ Birth defects ____ Hypertension
____ Arthritis ____ Tuberculosis ____ Cancer ____ Alllergies
____ Mental Illness

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications?_____

Mother's age at child's birth ? _____

Mother's health during pregnancy?

____ Bleeding
____ Nausea
____ Illnesses
____ Hypertension
____ Diabetes
____ Physical or emotional trauma
____ Cigarettes, alcohol, drug consumption
____ Medications
____ Thyroid problems

DIET

Please describe your child's typical daily diet:

Breakfast:_____

Lunch: _____

Dinner: _____

Snacks: _____

To drink : _____

BIRTH HISTORY

Term: Full ____ Premature ____ Late ____ Weight at birth _____

Length of labor _____ Complications? _____

Did your child have any of the following problems shortly after birth?

____ Birth defects ____ Brain injuries ____ Blue baby
____ Cerebral palsy ____ Seizures ____ Jaundice
____ Colic ____ Fever ____ Rashes

Other _____

CHILD DEVELOPMENT

Child's sleep patterns (first year) _____

Food intolerances _____

Feeding: Breast fed ____ how long? _____ Formula? _____ milk/soy _____

Age began solids _____ Which foods ? _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS (mark **Y** if current, **P** for past symptoms)

____ Hives
____ Eczema
____ Bleeding gums
____ Nose bleeds
____ Acne
____ High fevers
____ Chronic rash
____ Hearing loss
____ Diarrhea
____ Sore throats
____ Headaches
____ Frequent colds
____ Wheezing
____ Cough

____ Burning of urine
____ Frequent urination
____ Heart murmur
____ Vomiting spells
____ Anemia
____ Stomach aches
____ Jaundice
____ Easy bruising
____ Flat feet
____ Constipation
____ Gas
____ Bleeding tendency
____ Joint pains
____ Dizzy spells

____ Bloody urine
____ Cries easily
____ Nervous
____ Sleep problems
____ Night sweats
____ Sensitive to light
____ Body/ breath odor
____ Motion/ car sickness
____ No appetite
____ Nightmares
____ Canker sores
____ Unusual fears
____ Excessive fatigue
____ Hair loss

Thank you. We look forward to helping your child in any way we can.