



Medication Form

Name: _____ Date Completed: _____

Address: _____

Phone Number: _____ Birth Date: _____

Emergency Contact/ Phone: _____

E-Mail _____

(We give notice of all our sales and your birthday gift certificate through e-mail.)

Allergies and Drugs to Avoid/Adverse Reactions:

Please list any other special dietary information, or foods you can or will not eat. (ex: vegan, vegetarian, etc.)

Current Medications:

List all medications you are taking, include over-the-counter (e.g., supplements, prescriptions, aspirin, antacids).

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Date Started: _____ Date Discontinued: _____

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Date Started: _____ Date Discontinued: _____

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Date Started: _____ Date Discontinued: _____

Medication: _____ Dosage: _____

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Date Started: _____ Date Discontinued: _____

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Date Started: _____ Date Discontinued: _____

Medication: _____ Dosage: _____

Reason for Taking: _____ Directions: _____

Date Started: _____ Date Discontinued: _____

Immunization Record:

(Include dates administered)

Tetanus _____ Pneumonia Vaccine _____ Flu Vaccine _____

Hepatitis Vaccine _____ Other _____



PEDIATRIC INTAKE FORM

Patient Name: _____ DOB: _____ Age: _____

Sex (m/f): _____ Grade of School: _____

Mother's Name and Occupation: _____

Father's Name and Occupation: _____

Parents are (circle): Married Separated Divorced Living Together Other: _____

Reason for Office Visit: _____

Has child been seen by any other doctor(s) for this complaint? Yes No Past

Regular Pediatrician name and city located in: _____

Last time you had blood work done and with what physician: _____

List All Surgeries & Hospitalizations, including date occurred:

- 1) _____ 4) _____
- 2) _____ 5) _____
- 3) _____ 6) _____

List All medicines (from drugstore or prescription) child is on now:

- 1) _____ 4) _____
- 2) _____ 5) _____
- 3) _____ 6) _____

List all supplements child is taking:

- 1) _____ 4) _____
- 2) _____ 5) _____
- 3) _____ 6) _____

Any known Allergies to food, drugs, environment, animals: _____

Previous Medical History

YES (Y) indicates the child gets the problem **regularly**; **NO (N)** indicates the child **never** had the problem; **PAST (P)** indicates the child had the problem in the **past, but not recently**. Please circle the correct one for your child.

Ear Infections: Y N P If has had, how many total: _____

Colds: Y N P If has had, how many total: _____

Strep Throat: Y N P If has had, how many total: _____

How many times has the child taken antibiotics: _____

What other medicines has the child taken and how often:

- 1) _____ 3) _____
- 2) _____ 4) _____

Patient Name: _____ DOB: _____ Age: _____

Hearing Tests Normal: Yes No Not Tested
Vision Tests Normal: Yes No Not Tested
Speech Impediments: Yes No Past
Learning Impediments: Yes No Past

Vaccination History:

YES, has had; NO, has not; SOME, did not finish all shots:

MMR: Yes No Some DPT: Yes No Some Hep B: Yes No Some
Hib: Yes No Some Chicken Pox: Yes No Some Polio: Yes No Some

Other: _____

Any reactions to vaccinations? If so, please explain: _____

Family History:

Allergies: Y N P Obesity: Y N P Cancer: Y N P
Tuberculosis: Y N P Mental Illness: Y N P Cardiovascular Disease: Y N P
Diabetes mellitus: Y N P

Ethnic Background: _____

Mother's Pregnancy History:

Age at conception: _____ Did she have other children already? Yes No

Health During Pregnancy:

Smoking: Y N Diabetes: Y N Coffee: Y N Nausea/Vomiting: Y N Recreational Drugs: Y N
Emotional Stress: Y N Preeclampsia: Y N Length of Labor : _____ Vaginal Birth: Y N
Traumatic Birth: Y N If the birth was difficult, please explain: _____

Health of baby at birth: _____

Health History of Child:

Child Breastfed: Y N For how Long: _____ When put on formula: _____
What Formula was used: _____ When was child put on solid food: _____
When did child walk: _____ Talk: _____ Develop Teeth: _____

Jaundice as baby:	Y N	Colic:	Y N
Cradle Cap:	Y N	Anemia:	Y N
Eczema or Psoriasis:	Y N	Asthma:	Y N
Diarrhea:	Y N	Warts:	Y N
Constipation:	Y N	Nightmares:	Y N
Finicky Eating:	Y N	Bed-wetting:	Y N
Poor Teeth:	Y N	Tantrums:	Y N
Chronic Sniffles:	Y N	Disobedient:	Y N
Bad Foot Odor:	Y N	Fears/Phobia:	Y N
Very Sweaty Baby/Child:	Y N	Diaper Rash:	Y N
Hyperactivity:	Y N	Early Puberty:	Y N
Growing Pains:	Y N	Stomach Aches:	Y N

Patient Name: _____

DOB: _____

Age: _____

Any Particular household stressors child has witnessed or gone through:

1) _____

2) _____

3) _____

4) _____

Toxin Exposure

Has the child ever lived near a refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? _____

Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health at all? _____

Does the child seem particularly sensitive to perfumes, gasoline or other vapors? _____

Do you spray pesticides, herbicides or other chemicals around your home? _____

Typical Day's Diet

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Allergies

List all known Allergies (food, drugs, environment): _____

