

BIG SKY INTEGRATIVE HEALTH, PLLC
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BELGRADE, MT 59714
(406)-388-6676

PEDIATRIC INTAKE FORM (6-12 years)

Name _____ Date _____
Age ____ Date of Birth ____ / ____ / ____ female _____ male _
Mother's name _____ Father's name _____
Address _____
City _____ State _____ Zip Code _____
Telephone # (home) _____
How did you hear about this clinic _____
Health insurance: Company _____
Policy/I.D. No. _____ Group/code No. _____
Name policy is in _____

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?

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 environmental? _____

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) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

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
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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

