A Family Wellness Center
330 NE 102nd Ave.
Portland, OR 97220
(503) 252-9181

Pediatric Intake
Birth to 10 Years of Age

Name (First, Middle, Last)_____ Date_____
Age _____ Date of Birth _____ Sex: M F
Mother or Guardian _____ Father or Guardian _____
Address _____ City _____
State _____ Zip _____ Telephone (Home) _____

Are you:
Next of kin or other to reach in an emergency _____
Relationship _____ Address _____
Telephone (Home) _____ Telephone (Work) _____
How did you hear about the clinic? _____

What are your child's most important health problems?_____
_____

Insurance Information

Primary Insurance:
Name of Insured(First, Middle, Last)_____ Date of Birth _____
Relationship to Insured: _____ Address: _____
ID#: _____ Policy #:
_____
Group #: _____ Group Name: _____
_____
Insurance Company: _____ Telephone #: _____
Insurance Address: _____
How much is your deductible? _____ How much is your Copay? _____

Secondary Insurance:
Name of Insured(First, Middle, Last)_____ Date of Birth _____
Relationship to Insured: _____ Address: _____
ID#: _____ Policy #: _____
Group #: _____ Group Name:
_____
Insurance Company: _____ Telephone #: _____
Insurance Address: _____
How much is your deductible? _____ How much is your Copay? _____

I authorize the release of any medical information necessary to process insurance claims. I also authorize payment of medical benefits to A Family Wellness Center for services rendered.

_____ _____
Patient's or Authorized Person's Signature **Date**

Medications

	now	past		now	past		now	past
aspirin	___	___	antibiotics	___	___	decongestant	___	___
Tylenol	___	___	anti-histamine	___	___	ibuprofen	___	___
inhalers	___	___	asthma meds	___	___	topical steroids	___	___
_____	___	___	_____	___	___	_____	___	___

others
Allergies to medicines _____

Medical History

___ chicken pox ___ scarlet fever ___ bronchitis___ tonsillitis, no. of times ____
___ measles ___ pneumonia ___ rubella ___ ear infections, no. of times ____
___ mumps ___ frequent cold ___ eczema ___ asthma
___ croup ___ other _____

X-Rays and Special Studies

	when	where	results
electroencephalogram			
psychological evaluation			
hearing			
speech/language			

Injuries/ Surgeries/ Hospitalizations

_____
_____
_____

Immunizations

___ measles ___ polio ___ MMR ___ small pox ___ diphtheria
___ mumps ___ DPT ___ tetanus ___ influenza ___ others _____
Any adverse reactions to immunizations? (Please specify)_____
_____

Family History

___ heart disease ___ diabetes ___ birth defects ___ cancer ___ mental illness
___ hypertension ___ arthritis ___ tuberculosis ___ allergies ___ hay fever
___ eczema ___ others _____

Previous pregnancies by natural mother, miscarriages or complications: _____
_____
_____
Mother's age at child's birth _____
Mother's health during pregnancy:
___ bleeding ___ hypertension ___ illness ___ cigarettes, alcohol, drugs
___ nausea ___ diabetes ___ thyroid problems ___ physical or emotional trauma

Birth History

Term: full ___ premature ___ late ___ weight at birth _____
length of labor _____ complications _____
As a baby, did your child have any of the following problems?

___ jaundice	___ diarrhea	___ birth defects	___ rashes
___ colic	___ fever	___ cerebral palsy	___ allergies
___ blue baby	___ seizures	___ birth injuries	___ other _____

Feeding: breast fed ___ how long? ___ formula ___ milk/soy ___
Age the child began: solid foods _____ sitting _____ crawling _____ walking _____ first words _____
Child's sleep patterns during the first year _____
_____

Symptoms

Please circle: Y = a condition your child has now. N = never had. P = has had in the past.

acne	Y	N	P	easy bruising	Y	N	P	joint pains	Y	N	P
anemia	Y	N	P	eczema	Y	N	P	motion/car sick	Y	N	P
bleeding gums	Y	N	P	excessive fatigue	Y	N	P	nervous	Y	N	P
bleeding tendency	Y	N	P	flat feet	Y	N	P	nightmares	Y	N	P
bloody urine	Y	N	P	frequent colds	Y	N	P	night sweats	Y	N	P
body/ breath odor	Y	N	P	frequent headaches	Y	N	P	no appetite	Y	N	P
burning of urine	Y	N	P	frequent urination	Y	N	P	nose bleeds	Y	N	P
canker sores	Y	N	P	gas	Y	N	P	sensitive to light	Y	N	P
chronic rash	Y	N	P	hair loss	Y	N	P	sleep problems	Y	N	P
constipation	Y	N	P	hearing loss	Y	N	P	sore throats	Y	N	P
cough	Y	N	P	heart murmur	Y	N	P	stomach aches	Y	N	P
cries easily	Y	N	P	high fevers	Y	N	P	unusual fears	Y	N	P
diarrhea	Y	N	P	hives	Y	N	P	vomiting spells	Y	N	P
dizzy spells	Y	N	P	jaundice	Y	N	P	wheezing	Y	N	P

Any other condition not mentioned? _____

Diet

Please describe your child's typical daily diet:

Food intolerances (if known):