

PEDIATRIC PATIENT INTAKE

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Number of Siblings: \_\_\_\_\_ Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ Current Weight \_\_\_\_\_

Purpose of Today's Visit: \_\_\_\_\_

Type of Birth: Normal Vaginal  Forceps  Breech  C-Section

Home  Birth Center  Hospital

Problems During Pregnancy: \_\_\_\_\_

Problems During Labor/Delivery: \_\_\_\_\_

Medications Given During Labor/Delivery: \_\_\_\_\_

Infant Feeding: Breast  Bottle  Formula

Number of Hours Sleeping at Night: \_\_\_\_\_ Quality of Sleep: Good  Fair  Poor

Obstetrician/Midwife: \_\_\_\_\_

Pediatrician/Family Doctor: \_\_\_\_\_

Date of Last Visit to Doctor: \_\_\_\_\_ Purpose: \_\_\_\_\_

Choose to Immunize? Yes  No

Has/Does this Child Suffer from:

- Poor Appetite       Bed Wetting       Neck Problems       Backaches
- Tuberculosis       Headaches       Hyperactivity       Digestive Disorders
- Walking Problems       Asthma       Sinus Trouble       Stomach Aches
- Chronic Ear Aches       Constipation       Diarrhea       Behavioral Problems
- Ruptures/Hernia       "Growing Pains"      Other: \_\_\_\_\_

Has your child ever been treated on an Emergency basis? Please describe: \_\_\_\_\_

Surgery: \_\_\_\_\_

Medications: \_\_\_\_\_

Accidents: \_\_\_\_\_

Family History: \_\_\_\_\_

Authorization for Care of Minor

I hereby authorize Goode Integrative Health Care and its' doctors to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian)

Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Witness: \_\_\_\_\_