Health Pointe Jacksonville
3840 Belfort Road, #305
Jacksonville, FL 32216
904-448-0046

Pediatric Intake Form

Patient's name: _____ Date of first visit: _____

Age: Date of Birth (month/day/year): __/__/__ Gender: __ female ___ male

Mother's name: _____ Father's name:_____

Address: _____ City:_____ Zip: _____

Phone# (home): (___)_____ Parent's work/cell phone# (___)_____

Parent's e-mail address: _____

Child's GP or Pediatrician: _____

Current health concerns: _____

MEDICAL HISTORY

Chicken pox __ Scarlet fever __ Roseola __ Mononucleosis __ Measles__ Pneumonia __
Strep throat __ Impetigo__ Mumps __ Whooping Cough __ Ear Infections__
Rubella __ Rheumatic fever__ other (please list) _____

What screening tests has your child had? (blood, hearing, vision, etc)_____

Serious Illnesses/Injuries/Surgeries/Hospitalizations (please list): _____

Please list all current medications (prescription, over the counter, vitamins, herbs, homeopathies, etc.)

Please list any past prescription medications: _____

IMMUNIZATIONS

MMR ____Polio____ Prevnar____ Chicken Pox___ H.Influenza B____ DTaP____ Influenza ____
Hepatitis B___ Hepatitis A___ Other: _____

Any adverse reactions to vaccines: yes no If yes, please describe:_____

FAMILY HISTORY

Heart disease __ Diabetes__ Birth abnormality __ Celiac disease __ Hypertension __
Arthritis __ Tuberculosis __ Eczema__ Cancer___ Allergies __ Mental illness ___ Asthma__
Other: _____

BIRTH MOTHER'S PRENATAL HISTORY

Mother's age at child's birth? ___ Mother's health during pregnancy? _____

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Pediatric Intake Form

MEDICAL HISTORY

IMMUNIZATIONS

FAMILY HISTORY

BIRTH MOTHER'S PRENATAL HISTORY

Were any of the following experienced during pregnancy?

Bleeding __ Physical or emotional trauma __ High blood pressure __ Nausea/Vomiting __
Cigarettes, alcohol, drug consumption __ Thyroid problems __ Illnesses __ Surgery __
Medications __ Gestational diabetes__ Depression/Anxiety__ Other_____

CHILD'S BIRTH HISTORY

Term: ___Full Premature: _____ weeks Late: ___ weeks Weight at birth: ___ lbs,__ oz.

Length of labor _____ Any complications? _____

Birth: vaginal ___ C-section ___ Induced Forceps Suction ___Anesthesia used

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

Birth abnormality_____ Birth injuries _____ Blue baby __Cerebral palsy _____
Seizures __ Jaundice __ Colic __ Fever __ Rashes __

Other (explain):_____

FEEDING

Breastfed? ___ yes ___no How long? _____Formula? ___ yes ___no If Yes: ___cow's milk ___soy ___other
Child's sleep patterns _____

How would you describe your child's temperament? _____

Food or environmental sensitivities or allergies (if known) _____

Any dietary restrictions (religious, vegetarian, vegan, etc.)? _____

Age began solids ___ Which foods? _____

Typical daily diet:_____

Age began: Sitting ____ Crawling ____ Walking ____ Talking ___

SYMPTOMS (mark Y if current, P significant past symptom)

Hives	Sleep problems	Easy bruising	Frequent colds
Burning of urine	Acne	Motion/car sickness	Bleeding tendency
Bloody urine	Anemia	Diarrhea	Unusual fears
Eczema	Night sweats	Earaches/Infections	Wheezing
Frequent urination	High fevers	No appetite	Joint pains
Cries easily	Stomach aches	Sore throats	Excessive fatigue
Bleeding gums	Sensitive to light	Constipation	Cough
Heart murmur	Chronic rash	Nightmares	Dizzy spells
Nervous	Jaundice	Headaches	Hair loss
Nose bleeds	Body/breath odor	Gas	
Vomiting spells	Hearing loss	Canker sores	

Other: _____

Please explain briefly what you would like to see as a result of acupuncture treatments?

_____