PEDIATRIC INTAKE FORM

Child's Name____________________ Parents name:____________________

Birthdate____________ Address:____________________

Weight__________ ____________________

Height__________

Phone:H)______________

W)______________

Current reason for seeking care:

Current symptoms:

Relevant health history:

Overall health concerns:

Pediatricians Name:

Currently under treatment? NO

YES, for what:

Taking any Medication?
Supplements?

Has this child received any of the standard immunizations? YES NO

Please make comments about any of the following areas:

appetite:

digestion:

stool:

nasal congestion:

sleep habits:

activity level:

Any other comments or concerns: