

NeuroWellness

Child/Teen Intake Form and Medical History

Directions for Parents: In order for us to fully evaluate your child or teenager, please fill out the following intake form and medical history to the best of your ability. We realize we're asking a lot of information and you may not remember or have access to all of it, but please do the best you can.

PATIENT IDENTIFICATION

Name _____ Birth Date _____ Age _____ Sex _____
School _____ Grade _____ Natural Mother _____
Natural Father _____
Address _____
City _____ State _____ Zip _____
Home Phone # _____ Parent Work # _____ (specify) mom or dad
Who is the child currently living with? _____

REFERRAL SOURCE

Referral Source _____

MAIN PURPOSE OF THE CONSULTATION (Please give a brief summary of the main problems)

WHY DID YOU SEEK THE EVALUATION AT THIS TIME?

What do you want NeuroWellness to do for your child, yourself or your family?

PRIOR ATTEMPTS TO CORRECT PROBLEMS/PRIOR HISTORY

(Please include contact with other professionals, medications, types of treatment, etc.)

NeuroWellness

MEDICAL HISTORY

Name: _____ Date: _____

Current medical problems/medications: _____

Past medical problems/medications: _____

Other doctors/clinics seen regularly: _____

Any history of head trauma? (Describe): _____

Ever any seizures or seizure like activity? _____

Any periods of spaciness or confusion? _____

Prior hospitalizations (place, cause, date, outcome): _____

Allergies/drug intolerances (describe): _____

Approximate number of rounds of antibiotics your child has been given _____

Present Height _____ Present Weight _____

A. Pregnancy and Birth

Mother's age at birth _____

Maternal illness during pregnancy? No Yes

Any medications taken? No Yes

Was the baby on time (< or >37 wks)? No Yes

Was the baby breech? No Yes

What was the birth weight? _____

Did the baby have any trouble while in the hospital (jaundice, infection, breathing problems)? No Yes

If so, what kind? _____

B. Past Medical History

Where was your child's last check-up? _____ When? _____

Allergic reaction to meds, food, insects? No Yes Which ones? _____

Any serious reaction to immunizations? No Yes Which ones? _____

Any hospitalizations besides birth? No Yes For what? _____

Any serious injuries? No Yes What kinds? _____

C. Family History

Are the child's parents in good health? No Yes

Circle any diseases that this child's parents, grandparents, siblings, aunts, uncles, or cousins have had:

Anemia, asthma, allergies, eczema, diabetes, high blood pressure, heart trouble, high cholesterol, tuberculosis, mental illness, drug problems, inherited illnesses, cancer, AIDS, learning disorders, ADD/ADHD, strabismus

List age sex, and gender of siblings : _____

Have any of your children died? No Yes

D. Feeding and Nutrition

Was there severe colic or any unusual feeding problems during the first 3 months? No Yes

If breast fed, for how long? _____

Does your child take vitamins or fluoride? No Yes

Do they use homeopathic or herbal medicines? No Yes

E. Review of Systems

Has your child had:

Frequent ear infections?	No	Yes
Eye problems, glasses?	No	Yes
Frequent colds or sore throats?	No	Yes
Chickenpox?	No	Yes
Asthma, pneumonia, recurrent cough?	No	Yes
Heart murmur or heart problems?	No	Yes
Problems with urination, urinary tract infections?	No	Yes
Frequent diarrhea or constipation?	No	Yes
Convulsions or other nervous system problems?	No	Yes
Eczema, hives, or other skin problems?	No	Yes
Anemia or other blood problems?	No	Yes

Please list any other medical problems:

List any sub-specialists your child has seen:

F. Development/Behavior

Age your child sat alone? _____

Age your child walked alone? _____

Were they saying words by 18 months?	No	Yes
Do they have trouble sleeping?	No	Yes
Have they had any trouble in school?	No	Yes
Do they get along with other children?	No	Yes

Circle if your child has had any of the following: *thumb sucking, bed wetting, problems with toilet training, hyperactivity, nightmares, speech problems, problems with discipline***G. Safety/Environment**Are the parents of the child: *married, divorced, separated, deceased*

Is your child adopted? No Yes

The child is also in: *day care, preschool, with nanny, with relatives*

Are there any pets at home? No Yes

Are there smokers in the child's home? No Yes

Do you have a pool, spa, or pond? No Yes

Does your child always wear a helmet when bicycling or skating? No Yes

Does your child always use a car seat/seatbelt? No Yes

H. Records

Do you have a record of immunizations? No Yes