



# Desert Wellness Center

Family Medicine using Modern Science and Ancient Wisdom

### Pediatric Initial Intake

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Sex: M F Grade in School: \_\_\_\_\_ Are both Parents actively involved in child's life: Y N

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

Concerns in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Allergies to Food or Medication:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Names of Pediatricians seen: \_\_\_\_\_

Date of Last:

Doctor's visit: \_\_\_\_\_ Blood work: \_\_\_\_\_ Dental Exam: \_\_\_\_\_ Eye Exam: \_\_\_\_\_

Current Medications and supplements (include dosage): \_\_\_\_\_  
 \_\_\_\_\_

Previous Hospitalizations and surgeries (include date): \_\_\_\_\_  
 \_\_\_\_\_

Family History:

<u>Family Member</u>	<u>Age if Living</u>	<u>Age of Death</u>	<u>Reason of Death</u>
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Siblings			
Children			

<u>Disease</u>	<u>Family Member</u>
Heart attack/stroke	
Cancer (include type)	
Mental Illness	
Heart Disease	
High Blood Pressure	
Osteoporosis	
Asthma/allergies	
Autoimmune(RA,Lupus,etc)	
Diabetes	

**Vaccination History:**

Please indicate if Yes (Y), No (N) or had Some (S):

MMR: Y N S Hemophilis (Hib): Y N S DPT: Y N S  
 Polio: Y N S Chicken Pox: Y N S Hepatitis B: Y N S

Other Vaccinations: \_\_\_\_\_



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### Pregnancy History:

Mother's age at conception: \_\_\_\_\_ Length of Labor: \_\_\_\_\_ Child's Health at Birth: \_\_\_\_\_  
 Prior Pregnancies: Y N Alcohol: Y N Recreational Drugs: Y N  
 Smoking: Y N Preeclampsia: Y N Vaginal Birth: Y N  
 Gestational Diabetes: Y N Complications of Pregnancy: \_\_\_\_\_

### Previous Medical History:

Child Breast Fed: Y N For how long: \_\_\_\_\_ Age when Formula: \_\_\_\_\_  
 Type of Formula: \_\_\_\_\_ When were they put on solid food: \_\_\_\_\_  
 Walk: \_\_\_\_\_ Talk: \_\_\_\_\_ Teeth: \_\_\_\_\_ First Menses: \_\_\_\_\_  
 How many times has the child been on Antibiotics: \_\_\_\_\_

### Review of Systems (Younger Children)

Indicate yes (Y), No (N), or passed (P):

Jaundice	Y	N	P	Cradle Cap	Y	N	P	Eczema/Psoriasis	Y	N	P
Diarrhea	Y	N	P	Constipation	Y	N	P	Finicky Eater	Y	N	P
Poor teeth	Y	N	P	Chronic Sniffles	Y	N	P	Bad Feet Odor	Y	N	P
Very Sweaty	Y	N	P	Growing Pains	Y	N	P	Hyperactivity	Y	N	P
Colic	Y	N	P	Bed wetting	Y	N	P	Early Puberty	Y	N	P
Anemia	Y	N	P	Tantrums	Y	N	P	Stomach Aches	Y	N	P
Asthma	Y	N	P	Disobedient	Y	N	P	Abnormal Vision	Y	N	P
Warts	Y	N	P	Fears/phobia	Y	N	P	Abnormal Hearing	Y	N	P
Nightmares	Y	N	P	Diaper Rash	Y	N	P	Abnormal Speech	Y	N	P
Ear Infections	Y	N	P	Strep Throat	Y	N	P	Learning Problems	Y	N	P

### Review of Systems (Older Children)

Skin rash	Yes	No	Swollen Glands	Yes	No	Nausea	Yes	No
Hives	Yes	No	Problems Speaking	Yes	No	Gas/Bloating	Yes	No
Warts	Yes	No	Asthma	Yes	No	Constipation	Yes	No
Headaches	Yes	No	Pneumonia	Yes	No	Diarrhea	Yes	No
Head Injury	Yes	No	Cough	Yes	No	Stomach Pain	Yes	No
Nose Bleeds	Yes	No	Bronchitis	Yes	No	Leg Cramps	Yes	No
Allergies/Congestion	Yes	No	Shortness of Breath	Yes	No	Muscle Aches	Yes	No
Frequent Colds	Yes	No	Wheezing	Yes	No	Seizures	Yes	No
Dry/Red/Itchy Eyes	Yes	No	Murmurs	Yes	No	Fainting	Yes	No
Styes	Yes	No	Chest Pain	Yes	No	Depression	Yes	No
Vision Problems	Yes	No	Rheumatic Fever	Yes	No	Anxiety	Yes	No
Cavities	Yes	No	Urinary Infections	Yes	No	Eating Disorder	Yes	No
Canker Sores	Yes	No	Kidney Stones	Yes	No	Obsessive	Yes	No
Gum Disease	Yes	No	Heartburn	Yes	No	ADD/ADHD	Yes	No

### Please Describe a Typical Meal

Breakfast	Lunch	Dinner

Snacks: \_\_\_\_\_ Beverages: \_\_\_\_\_