SOUTHERN MAINE INTEGRATIVE HEALTH CENTER, LLC

Date:
Dates Revised:

Child Intake Form

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record. Thank you for taking the time to fill out this form. This information is very important in the assessment of your care.

Child's Name: (Last, First, M.I.):		M F	DOB:
Address:		Birthplace:	
City:		State:	Zipcode:
Phone:	Mother:	Father:	
Parent's marital status:			
Family physician:		Phone Number:	
Referred by:			
What are your child's main health concerns?	(list in order of importance, form most important to least)		
	Include the date problem started.		
1			
2			
3			
4			
5			

PERSONAL HEALTH HISTORY

DATE OF LAST PHYSICAL EXAM:	WEIGHT:	HEIGHT:
HOURS OF SLEEP AT NIGHT:	NUMBER OF TIMES WAKE UP DURING THE NIGHT:	
BLOOD TYPE:	DATE OF LAST BLOOD TEST:	WHY?

LIST THEIR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS

NAME THE DRUG	STRENGTH	FREQUENCY TAKEN

ALLERGIES TO MEDICATIONS:

NAME THE DRUG	REACTION THEY'VE HAD

DENTAL

ANY DENTAL FILLINGS? ¨ **YES** ¨ **NO** **HOW MANY?**

Immunizations and dates:	¨ Tetanus	¨ Mumps
	¨ Hepatitis B	¨ Chickenpox
	¨ Influenza	¨ Measles
	¨ Pertussis	¨ Diptheria
	¨ Polio	¨ Smallpox
	¨ Other	¨ Rubella
Did your child have a reaction to any of these vaccinations? (e.g. fever) ? Yes ? No	If yes, what type of a reaction?	
List any medical problems that other doctors have diagnosed		

Review of Body Systems

Please check "Y" if your child has the condition now and "P" if they had it in the past.

¨ Y ¨ P Jaundice
¨ Y ¨ P Lack of energy
¨ Y ¨ P Hyperactivity
¨ Y ¨ P Difficult to please
¨ Y ¨ P Cries a lot
¨ Y ¨ P Bedwetting
¨ Y ¨ P Convulsions
¨ Y ¨ P Ear infections
¨ Y ¨ P Eczema/Rashes
¨ Y ¨ P Constipation
¨ Y ¨ P Vision Problems
¨ Y ¨ P Learning Problems
¨ Y ¨ P "Problem Child"
¨ Y ¨ P Nervous Child
¨ Y ¨ P Tantrums
¨ Y ¨ P Breathing Problems
¨ Y ¨ P Heart Murmur
¨ Y ¨ P Digestive Upsets
¨ Y ¨ P Diarrhea
¨ Y ¨ P Hearing Problems
¨ Y ¨ P Teeth Problems

Other:________________________________

Bowel movements per day:______________

Color:______________________________

Other:_____________________________

Childhood diseases:

¨ Y ¨ P Frequent Colds
¨ Y ¨ P German Measles
¨ Y ¨ P Whooping Cough
¨ Y ¨ P Injuries/Burns
¨ Y ¨ P Measles
¨ Y ¨ P Chicken Pox
¨ Y ¨ P Diptheria
¨ Y ¨ P Accidents

Operations:____________________
For what:______________________
Hospitalizations:________________
For what:______________________
Other:_________________________

BIRTH HISTORY

Weight at Birth:		
Any birth complications (during or after delivery):		
Delivery: : Normal Premature Caesarian		
Where?: Home Hospital		
Number of hours in labor?		
Rh Blood Problem	Yes	No
Forceps aided:	Yes	No
Difficult?	Yes	No
Drug aided?	Yes	No
If yes, what drugs?		
Feeding:		
Breast?	Yes	No
If yes, how many months?		
Bottle?	Yes	No
Type of milk?		
Solid foods started at months		
What foods were introduced first?		
Mother's Pregnancy History:		
Difficulties in becoming pregnant?	Yes	No
If yes, what?		
Did you receive Rhogam shot?	Yes	No
Was the pregnancy stressful for you?	Yes	No
Did you have any of the following?		
Nausea Anemia Hospitalization		
Vomiting Shocks/Trauma Extreme Tiredness		
How many amalgams did you have during your pregnancy?		
Were any of the following used during the pregnancy?		
Cigarettes Alcohol Recreational Drugs If yes, what?		
X-rays Ultrasound Sedatives Sleeping Pills Antibiotics Iron Supplements		
Were you on a special diet? Yes No		
How many lbs. did you gain?		