HEALTH HISTORY QUESTIONNAIRE
Child Intake Form

Child's Name: (Last, First, M.I.): ☐ M ☐ F ☐ **non binary**	**DOB:**
Address: **Birthplace:**	
City: **State:**	**Zip code:**
Mother's name and phone number: **Father's name and phone number:**	
Parent's marital status:	
Pediatrician: **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:**

LIST THEIR PRESCRIBED DRUGS/INHALERS AND OVER -THE-COUNTER MEDICATIONS

NAME THE DRUG	**STRENGTH**	**FREQUENCY TAKEN**	**PRESCRIBER**

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		☐ COVID

If yes, explain reactions:

List any medical problems that other doctors have diagnosed:

Child's name: ____

PARENT'S/ GUARDIAN'S signature____**Date:**________________________