Pediatric Intake Form

Account # _____

PERSONAL INFORMATION

PLEASE PRINT

First Name:_____**M.I.**_____**Last Name**:_____ **Birthdate**:_____/_____/_____

Gender: □ Male □ Female □ Unspecified **Age**: _____

Address:_____**City**:_____**State:**_____**Zip:**_____

Primary Phone:_____ **Cell Phone**:_____

Email:_____

By providing my email address, I authorize my doctor to contact me via the email address provided.

Contact Method: (check one) □ Primary Phone □ Cell Phone □ Work Phone □ Email □ Text Message

Who may we thank for referring you? _____

IN CASE OF EMERGENCY CONTACT

Name: _____

Relationship: _____

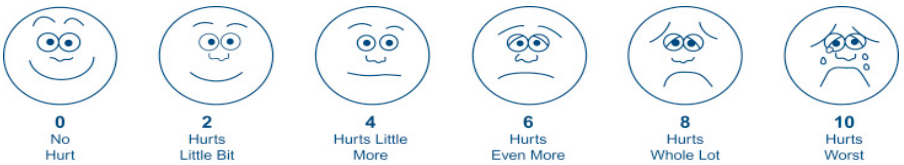
Phone Number: _____

REASON FOR VISIT

What is the reason for your visit today? _____

_____

When did this complaint begin? _____/_____/_____ **Is the condition getting worse?**: □ Yes □ No □ Unknown



Rate the severity of the pain from 0-10:

_____

Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting
□ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other _____

How often do you have this pain?: _____ **Is this pain:** □ Constant □ Come and go

Does the pain interfere with: □ School □ Sleep □ Daily Routine □ Other Activities: _____
Activities that are painful to perform: □ Sitting □ Standing □ Walking □ Bending □ Lying Down

FOR CHILDREN 5 YEARS OLD AND YOUNGER, please fill out SECTIONS 1-3. FOR CHILDREN 5-17, please skip to SECTION 3

1. PRENATAL / BIRTH HISTORY

Birth Weight_____ Type of birth: □ Normal/Vaginal □ Cesarean □ Unknown

Describe any problems during pregnancy:_____

_____

_____

Describe any problems during delivery: _____

_____

_____

Jaundice? □Yes □No Cyanosis? □Yes □No

Obstetrician / Physician / Midwife:_____

2. INFANT QUESTIONNAIRE:

Birth defects:_____

Infant Feeding: □Breast □ Formula/Brand:_____Number of bowel movements per day/type:_____

Child's average number of hours slept per night:_____ Quality of sleep: □Good □ Poor

Is your child able to do the following (check all that apply): □Respond to sound □ Follow object with eyes

□ Hold head up □ Sit alone □ Crawl □ Stand □ Walk alone

Childhood diseases (check all that apply): □ Chickenpox □Mumps □ Rubella □ Rubeola □Measles □Whooping cough

□ Other:_____

3. HEALTH HISTORY:

Pediatrician (clinic) / Family MD (clinic)_____

Has your child been treated on an emergency basis?_____

Reasoning:_____

What shots/immunizations has he/she had:_____

Any reactions to shots/immunizations?: _____

Please check **ALL** any of the following which your child has suffered from in the last 6 months.						**Family History** Mark **ALL** conditions that run in your family		**Relationship:** (Father,Mother,Sister, Brother)
□	Ear Infections	□	Growing Pains	□	Anemia	□	Cancer *Type:*	
□	Asthma / Allergies	□	Back Pain	□	Poor Appetite	□	Anemia	
□	Diabetes □ Type I or □ Type II	□	Bed Wetting	□	Fainting	□	Diabetes (check one) □Type I □ Type II	
□	Fevers	□	Acid Reflux	□	Neck Pain	□	Heart Problems / Stroke	
□	Cancer/Tumor	□	Seizures	□	Convulsions	□	High Blood Pressure	
□	Colic	□	Temper tantrums	□	Hyperactivity	□	Genetic Disorders	
□	Headaches	□	Colds/Flu	□	Dizziness	□	Rheumatoid Arthritis	
□	Scoliosis	□	Accident/Injuries	□	Digestive	□	Other (List):	
□	Problems/Excessive Gas	□	Ruptures/Hernias	□	Other(List):			

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and it's doctor(s) to administer care as they so deem necessary to my child. (Upon approval of parent/guardian)

_____ _____

Signature of Parent/Guardian Date **Witnessed by** Date

ASSIGNMENT AND RELEASE

ASSIGNMENT/AUTHORIZATION/RELEASE:

I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Dr. Thomas Baader all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

_____ _____

Signature of Parent/Guardian Date Relationship to patient