Arizona Integrative Medical Solutions
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Pediatric Intake Form

Name_____ Date of birth _____ Age _____ Sex ☐ M ☐ F

Grade of School: _____

Address: _____

City: _____ State:_____ Zip:_____

Best Contact Phone: _____ Email: _____

Mother's Name and occupation: _____

Father's Name and occupation: _____

Parents are: ☐ Married ☐ Separated ☐ Divorced ☐ Living Together ☐ Other

Insurance company: _____ Group #_____ Policy #_____

Regular Pediatrician name and city located in: _____

Referral To AIMS:_____

What are your child's main health concerns/reasons for your visit (Please list in Order of Importance)?

1. _____ Date First Noticed or Diagnosed:_____
2. _____ Date First Noticed or Diagnosed:_____
3. _____ Date First Noticed or Diagnosed:_____
4. _____ Date First Noticed or Diagnosed:_____
5. _____ Date First Noticed or Diagnosed:_____

Please list any Additional Questions or Expectations of your visit today:

_____

Has child been seen by any other doctor(s) for this complaint? ☐ Yes ☐ No ☐ Past

Has child had any blood work done? ☐ Yes ☐ No If yes, please list: _____

_____

Please list any operations or hospitalizations and the year they occurred:

1. _____ Date: _____

2. _____ Date: _____

3. _____ Date: _____

List All Accidents, Injuries, or Physical Traumas:

1._____ Date: _____

2. _____ Date: _____

3. _____ Date: _____

Please list all medicines (from drugstore or prescription) child is on now:

Pharmaceuticals	**Dose**	**When/How Often**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Please list all supplements—vitamins, minerals, herbs--child is taking:

Supplement	**Dose**	**When/How Often**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Imaging History:

X-rays: _____

Ultrasounds: _____

Cat Scans/MRI: _____

List All Known Sensitivities/Allergies/Reactions:

Drugs_____

Foods_____

Environmental_____

Previous medical history

Yes indicates the child gets the problem regularly; **N**o indicates the child never had the problem; **P**ast indicates the child had the problem in the past but not recently. Please circle the correct one for your child.

Ear Infections	Y	N	P	If has had, how many total in life:_____
Colds	Y	N	P	If has had, how many total in life:_____
Strep Throat	Y	N	P	If has had, how many total in life:_____
Asthma/Lung infections	Y	N	P	If has had, how many total in life:_____
Skin Conditions	Y	N	P	If has had, how many total in life:_____

How many times has your child taken antibiotics? _____

Has your child ever taken antacids? _____

Has your child taken many NSAIDS (Tylenol, Ibuprofen, Aleve, etc.)? _____

Most Recent Tests Performed			
Hearing Tests Normal	Y	N	Not Tested
Vision Tests Normal	Y	N	Not Tested
Speech Impediments	Y	N	Not Tested
Learning Impediments	Y	N	Not Tested

Vaccination History:

Yes— has had all shots; **N**o — has had no shots; Some — did not finish shots

MMR	Y	N	Some	DPT	Y	N	Some	Hep B	Y	N	Some
Hib	Y	N	Some	Chicken Pox	Y	N	Some	Polio	Y	N	Some
HPV	Y	N	Some								

Other vaccinations: _____

_____

Any reactions to vaccinations? If so, please explain: _____

_____

_____

Family history

Allergies: Y N P	Overweight/Obesity: Y N P	Cancer: Y N P
Tuberculosis: Y N P	Mental Illness: Y N P	Cardiovascular Disease: Y N P
Diabetes Mellitus: Y N P	Kidney Disease: Y N P	Lung Disease: Y N P
Auto-Immune Disease: Y N P	Addiction: Y N P	Arthritis/Osteoporosis: Y N P

Mother's Pregnancy history

Age at conception: _____ Did she have other children already? Yes No

Health During Pregnancy:

Smoking/Alcohol: Y N	Diabetes: Y N	Coffee/Caffeine: Y N
Nausea/Vomiting: Y N	Recreational Drugs: Y N	Emotional Stress: Y N
Preeclampsia: Y N	Length of Labor: _____hours	Vaginal Birth: Y N
High Blood Pressure: Y N	STD: Y N	

Traumatic birth: Yes No

If the birth was difficult please explain _____

_____

Health of baby at birth: _____

Child breastfed: Yes No For how long? _____

When put on formula? _____ What formula was used? _____

When was child put on solid food? _____

When did child walk? _____ Talk? _____

Develop Teeth? _____

Current Home Lifestyle:

Normal Wake Time: _____ Bed Time:_____ Naps: _____

Breakfast: _____am Lunch: _____pm Dinner: _____pm

Snack Times:

_____

Hours of TV/Computer/Internet/Cell phone per Day:_____

Total hours outdoor/exercising a day:_____

Does your Child interact well with family members & other children? ☐ Yes ☐ No

Who, if any person, does your child struggle to act well with? _____

Any bullying at school: ☐ Yes ☐ No

Any pets in the home? ☐ Yes ☐ No If yes, what type and how many of each? _____

_____

Do Any Animals Sleep with Child? ☐ Yes ☐ No ☐ Some

Any particular household stressors child has witnessed or gone through?

1._____

2._____

3._____

Health History of child

Jaundice as Baby:	Y	N	Colic:	Y	N
Cradle Cap:	Y	N	Anemia:	Y	N
Eczema or Psoriasis:	Y	N	Diarrhea:	Y	N
Constipation:	Y	N	Asthma:	Y	N
Finicky Eating:	Y	N	Warts:	Y	N
Poor Teeth:	Y	N	Bed-wetting:	Y	N
Night Terrors/Nightmares:	Y	N	Tantrums:	Y	N
Frequent Colds/Sniffles:	Y	N	Disobedient:	Y	N
Hyperactive/Impulsive:	Y	N	Lethargic/Low Energy:	Y	N
Growing Pains/Leg cramps:	Y	N	Diaper Rash:	Y	N
Stomach Aches:	Y	N	Overly Shy/Social Problems:	Y	N
Fears/Phobias:	Y	N	Overweight/Obese:	Y	N
Acne:	Y	N	Likes Themselves/Their Looks:	Y	N

Other Health Complaints Throughout the Years Not Listed Above:

_____

Toxin Exposure:

Has the child ever lived near a refinery or other highly polluted area? _____

Has the child ever lived in a house with lead paint? _____

Has the child ever lived in a house that had new paint, cabinets, carpeting installed and did that seem to affect their health at all? _____

Do you spray pesticides or herbicides around or in the house or use other toxic chemicals? _____

Does the child seem particularly sensitive to perfumes or other vapors? _____

Social Development History

Mother's Age? _____ Father's Age? _____ # Sisters: _____ # Brothers: _____

Does anyone in the home smoke? ☐ Yes ☐ No ☐ Some ☐ Past

Child is: ☐ Oldest ☐ Middle ☐ Youngest

Who spends the most time caring for your child? _____

Does your child go to daycare, preschool, or babysitter on a regular basis: ☐ Yes ☐ No

If so, how many times a week and for how long? _____

What, if any, are the most challenging behaviors you face with your child? _____

_____

What rewards system do you have in place for your child? _____

_____

What are the preferred methods of discipline/correction in the home by each parent? _____

_____

Diet:

Child's favorite foods/would eat all the time if possible: _____

Foods Child hates to eat: _____

How much of your food is organic? _____

Is your family's Diet? ☐ Omnivore ☐ Vegan ☐ Vegetarian ☐ Other (please define): _____