THE HOLISTIC CENTER AT BRISTOL SQUARE
hands on healing

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Pediatric Patient Intake

Child's Name _____

Mother's Name _____ Father's Name _____

Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Work Phone _____

Date of Birth _____ Age_____ ☐ M ☐ F Birth Weight _____Current Weight_____

Siblings _____ Birth Length_____Current Length_____

Purpose of Appointment _____

Has your child been treated on an emergency basis? ☐ No ☐ Yes _____

Pregnancy

OB / Midwife _____ Location _____

History / Problems _____

_____

_____

Labor / Birth

Birth Type ☐ Normal Vaginal ☐ Forceps ☐ Breech ☐ Cesarean

☐ Home ☐ Birthing Center ☐ Hospital

Apgar Scores _____ Present at Birth ☐ Jaundice (yellow) ☐ Cyanosis (blue)

History / Problems _____

_____

Pediatrician

Pediatrician _____ Location _____

Date of Last Visit _____ Purpose _____

Immunization History _____

Child's Health / Developmental History

Congenital Anomalies / Defects _____

Infant Feeding ☐ Breast ☐ Bottle ☐ Formula

Hours of Sleep at Night _____ Quality of Sleep ☐ Good ☐ Fair ☐ Poor

At what age did your child?

_____ Respond to Sound

_____ Crawl

_____ Follow Objects with Eyes

_____ Hold Head Up

_____ Stand

_____ Walk Alone

Has your child ever had?

☐ Chicken Pox
☐ Rubella
☐ Mumps
☐ Measles
☐ Rubeola
☐ Whooping Cough
☐ Other _____

Has your child ever suffered from?

☐ Dizziness
☐ Backaches
☐ Heart Trouble
☐ Chronic Earaches
☐ Diabetes
☐ Tuberculosis
☐ Hypertension
☐ Colds / Flu
☐ Headaches
☐ Asthma
☐ Allergies
☐ Hernia
☐ Digestive Disorders
☐ Sinus Trouble
☐ Constipation
☐ Poor Appetite
☐ Rheumatic Fever
☐ Orthopedic Problems
☐ Diarrhea
☐ Bed Wetting
☐ Hyperactivity
☐ Sugar Concentration
☐ Behavioral Problems
☐ Convulsions
☐ Paralysis
☐ Muscle Jerking
☐ Fainting
☐ Walking Problems
☐ Broken Bones
☐ Ruptures
☐ Neck Problems
☐ Arm Problems
☐ Leg Problems
☐ Growing Pains
☐ Joint Problems

Health History _____

_____

_____

Family History _____

_____

_____

Accidents / Falls _____

_____

_____

Medications _____

_____

Allergies _____

_____

Emergency Contact

Name _____

Relationship _____ Phone _____

Billing / Insurance

Insurance Name _____

Health Insurance # _____

Authorization for Care of Minor

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary for my son / daughter / ward.

Signature _____ Date _____

Witnessed _____

I realize that I am responsible for all fees charged by this clinic and that I will pay for all services as they are performed. X-rays remain the property of this clinic.

Signature _____ Date _____