SONORAN UNIVERSITY OF HEALTH SCIENCES | Clinical Care

PEDIATRIC INTAKE

Date: _____

CHILD's INFORMATION

Child's legal name:	
Preferred name, *if different:*	
Preferred pronouns:	
Date of birth:	
Gender identity:	
Sex assigned at birth:	

PARENTAL/GUARDIAN INFORMATION

Parent/Guardian #1 name:	
Parent/Guardian #2 name:	

Parents/Guardians listed above are: ☐ Living together ☐ Not living together

CHILD'S HEALTH INSURANCE INFORMATION

Insurance company: _____

Insurance ID #: _____ Group #: _____

Insurance holder's name: _____ Relationship to insurance holder: _____

Insurance holder's employer: _____

Copay: _____ Deductible (if applicable): _____ Amount used: _____

CHILD'S PHARMACY INFORMATION

Pharmacy name: _____ Phone: _____ Fax: _____

Address: _____ City/State: _____ Zip: _____

CONCERNS

Reason for today's visit:

Additional concerns:

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Biological FAMILY HISTORY

Have any biological relatives ever received any of the following diagnoses (if known)?

☐ Yes ☐ No ☐ Unknown

If Yes, check appropriate boxes and indicate relative(s) (e.g. maternal aunt, paternal grandmother, father, child, etc.)

☐ Allergies:	☐ High blood pressure:
☐ Asthma:	☐ Mental illness or addictions:
☐ Autoimmune disease:	☐ Osteoporosis:
☐ Cancer:	☐ Stroke:
☐ Diabetes:	☐ Tuberculosis:
☐ Heart attack:	☐ Other
☐ Heart disease:	

MEDICAL HISTORY

Does this child have a Primary Care Physician [or previous Pediatrician]? ☐ Yes ☐ No

If yes, please provide the following, if known:

Name:	
Address:	
Phone:	
Fax:	

Date of last well-child visit? _____

List all surgeries and hospitalizations, including reason and date of occurrence (if known):

Please list all major illnesses including date of occurrence (if known):

Has this child experienced abuse? ☐ Yes ☐ No

If Yes, please check all that apply.

- ☐ Mental/Emotional
- ☐ Physical
- ☐ Sexual

PREVIOUS EVALUATIONS

Check box if evaluation has occurred and provide date and result (if known):

	Yes	**Date/Result**
Allergy evaluation	☐	_____
Auditory evaluation	☐	_____

Blood work	☐	_____
Full physical exam	☐	_____
Learning evaluation	☐	_____
Nutritional evaluation	☐	_____
Psychological evaluation	☐	_____
Scale of intelligence	☐	_____
Speech and language evaluation	☐	_____

Medical Imaging History
X-ray/ MRI/CT Scan/ Ultrasound: Provide date(s), area(s) of body, and reason.

Vaccination History
Has this child ever had the **Disease (D), been Immunized (I), Neither (N) or Unknown (U)** for the following:

PEDIATRIC VACCINATIONS:
Disease (D), been Immunized (I), Neither (N) or Unknown (U)

	D	I	N	U	Date
Diptheria & Whooping Cough (Pertussis)	☐	☐	☐	☐	
Hemophilus (HiB)	☐	☐	☐	☐	
Tetanus	☐	☐	☐	☐	
Measles	☐	☐	☐	☐	
Mumps	☐	☐	☐	☐	
German Measles (Rubella)	☐	☐	☐	☐	
Chicken Pox	☐	☐	☐	☐	
Polio	☐	☐	☐	☐	
Meningococcal	☐	☐	☐	☐	

ADDITIONAL VACCINATIONS:
Disease (D), been Immunized (I), Neither (N) or Unknown (U)

	D	I	N	U	Date
COVID	☐	☐	☐	☐	
Hepatitis A	☐	☐	☐	☐	
Hepatitis B	☐	☐	☐	☐	
Influenza	☐	☐	☐	☐	
Human Papilloma Virus (HPV)	☐	☐	☐	☐	
Pneumococcal Conjugated Vaccine (PCV)	☐	☐	☐	☐	
Pneumonia	☐	☐	☐	☐	

Shingles	☐	☐	☐	☐	

Has this child had any adverse reactions to any vaccinations? ☐ Yes ☐ No
If Yes, please describe:

Is this child up to date on all immunizations for their age? ☐ Yes ☐ No, they are on an alternative vaccine schedule because:

Medications / Supplements
Please include ALL current prescriptions, over-the-counter drugs, vitamins, herbs, etc., including daily dose, approximate starting date and reason for use.

Can this child swallow pills? ☐ Yes ☐ No

Allergies
Does this child have any allergies? ☐ Yes ☐ No known or suspected allergies ☐ Unknown
If Yes, please check all that apply.

- ☐ Medication
- ☐ Food
- ☐ Environmental
- ☐ Other: _____

Please indicate specific allergy and describe reaction:

SOCIAL HISTORY
Has this child traveled outside the US within the past 12 months? ☐ Yes ☐ No
If Yes, please indicate where:

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Sleep
How many hours of sleep does this child usually get each night: _____

Diet
Does this child follow a special diet? ☐ Yes ☐ No
If yes, what type?_____

How many ounces/ml of water does this child drink each day? _____

How many meals does this child eat each day? _____

Does this child drink soda, sweetened juice, sports drinks or energy drinks?
☐ Daily ☐ Weekly ☐ Monthly ☐ Never

Does this child consume cannabis, tobacco, alcohol or other drugs?
☐ Daily ☐ Weekly ☐ Monthly ☐ Never

PATIENT BIRTH HISTORY

Birth weight: _____	Length: _____	Head circumference: _____
APGAR scores, if known: _____		Days spent in hospital: _____

Did this child spend time in the NICU (Neonatal Intensive Care Unit)? ☐ Yes ☐ No ☐ Unknown
If Yes, please explain:

Were there any medical concerns when the child was a newborn? ☐ Yes ☐ No ☐ Unknown
Please check all that apply:

☐ Birth anomalies (please specify):	☐ Jaundice
☐ Breathing problems	☐ Low muscle tone
☐ Feeding problems	☐ Other:

Were there any medical problems during pregnancy? ☐ Yes ☐ No ☐ Unknown
Please check all that apply:

☐ Bleeding	☐ Pre-eclampsia
☐ Diabetes	☐ Premature labor
☐ High blood pressure	☐ Surgery
☐ Hospitalization	☐ Toxemia
☐ Infection(s), please specify:	☐ Other:

Were any medications or drugs used during pregnancy? ☐ Yes ☐ No ☐ Unknown

Please check all that apply:

☐ Alcohol (specify amount):	☐ Prescription medication(s) (specify):
☐ Folic acid	☐ Tobacco (specify amount):
☐ Other drugs, including cannabis (specify):	☐ Other (specify):
☐ Prenatal vitamins	

Were any tests or procedures done during pregnancy? ☐ Yes ☐ No ☐ Unknown
Please check all that apply:

☐ Amniocentesis (results):	☐ Maternal serum screening (results):
☐ Carrier screening (please specify):	☐ Non-invasive Prenatal Testing (NIPT) (results):
☐ Chorionic Villi Sampling (CVS) (results):	☐ Ultrasound (results):
☐ Fetal MRI (results):	☐ Other (please specify):

Delivery:
Mother's age at delivery: _____

Length of pregnancy (weeks): _____

Labor: ☐ Spontaneous ☐ Induced, reason: _____

Delivery: ☐ Vaginal ☐ C-section

Were there any problems during the delivery? ☐ Yes ☐ No ☐ Unknown
If Yes, please describe:

PATIENT DEVELOPMENT HISTORY: Complete if child is 0-6 years old
Please indicate the approximate age in months for the following milestones

Milestone	**Approximate age in months**
Crawling	
Dry at night	
First words	
Potty trained	
Sitting up	
Spoke clearly	
Walking alone	

Is this child exposed to secondhand smoke? ☐ Yes ☐ No

Menstrual Cycle

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Age of first menses? _____

First day of last menses? _____

Length of menstrual bleeding? _____

Length of time between menstrual bleeding? _____

Does this child experience any of the following before or during menses?

☐ diarrhea/constipation	☐ abdominal cramping
☐ bloating	☐ increased fatigue
☐ food cravings	☐ backache
☐ mood changes	☐ breast tenderness/ swelling
☐ headaches	☐ other
☐ heavy bleeding	

Sexual History

Is this child sexually active, or have they had sex before? ☐ Yes ☐ No

Would this child like information about contraception and/or STI (sexually transmitted illness) prevention?

☐ Yes ☐ No

SIGNATURE: Patient or legally authorized individual	DATE:
PRINT NAME: Patient or legally authorized individual	RELATIONSHIP: (self, parent, legal guardian, personal representative, etc.)