Canyon Medical Center

2100 SW Camelot Ct
Portland, OR 97225
P: (503) 252-8125
F: (503) 256-8422
info@canyonmedcenter.com
www.canyonmedcenter.com

PEDIATRIC INTAKE FORM (6-12 years)

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Female: _____ Male: _____

Mother's name:_____ Father's name:_____

Address: _____

City:_____ State:_____ Zip Code:_____

Phone # (home): _____ Parent's # (work): _____

Parent's e-mail address: _____

How did you hear about our clinic? _____

HEALTH HISTORY QUESTIONNAIRE

Birth city & state: _____

Birth time: _____ Birth weight: _____

What are your child's most important health problems? List as many as you can in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Does your child have a contagious disease at this time? Y N

If yes, what? _____

PREVIOUS ILLNESSES

Rheumatic fever	Y N	German measles	Y N	Chicken pox	Y N
Measles	Y N	Tonsillitis	Y N	Ear infections	Y N
				approx. number_____	

Other _____
approx. number_____

Has your child had any of the following tests?	**WHEN**	**WHERE**	**RESULTS**
Electroencephalogram (EEG)_____			
Psychological evaluation_____			

Has your child had any of the following tests?	**WHEN**	**WHERE**	**RESULTS**
Hearing tests_____			

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Speech/Language tests_____

Hospitalizations/ Surgeries/ Injuries

What hospitalizations, surgeries or injuries has your child had?

_____

_____

Immunizations

Polio	Y N	Pertussis	Y N
Tetanus shot	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Influenza	Y N
Any adverse reactions?	Y N	If yes, what ? _____	

Allergies

Is your child hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmentals? _____

Breast fed? _____ How long? _____ Formula? milk / soy / other: _____

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Please list **any** prescription medications, over the counter medications, vitamins or other supplements your child is taking:

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

What expectations do you have for your child from working with our clinic?

Is there any information about your child's health that you would like to add?

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REVIEW OF SYSTEMS

Y = a condition now **P** = significant problem in the past **N** = never had **S**= Sometimes a problem

MENTAL/ EMOTIONAL

Mood Swings	Y	P	N	S
Irritability	Y	P	N	S
Hyperactivity	Y	P	N	S
Introvert/extrovert	Y	P	N	S
Motion/car sickness	Y	P	N	S
Anxiety/nervousness	Y	P	N	S
Cries easily	Y	P	N	S
Unusual fears	Y	P	N	S
Sleep problems	Y	P	N	S
Nightmares	Y	P	N	S

ENDOCRINE

Heat/cold intolerance	Y	P	N	S
Fatigue	Y	P	N	S
Excessive thirst	Y	P	N	S
Excessive hunger	Y	P	N	S
Low blood sugar	Y	P	N	S
High blood sugar	Y	P	N	S

SKIN

Rashes	Y	P	N	S
Eczema, Hives	Y	P	N	S
Acne, Boils	Y	P	N	S
Itching	Y	P	N	S

HEAD

Headaches	Y	P	N	S
Head Injury	Y	P	N	S
Dizzy spells	Y	P	N	S
High fevers	Y	P	N	S

EYES

Glasses or contacts	Y	P	N	S
Tearing or dryness	Y	P	N	S
Eye pain/strain	Y	P	N	S

EARS

Earaches	Y	P	N	S
Impaired hearing	Y	P	N	S

NOSE AND SINUSES

Frequent colds	Y	P	N	S
Nose Bleeds	Y	P	N	S
Stuffiness	Y	P	N	S
Hayfever	Y	P	N	S
Sinus problems	Y	P	N	S
Loss of smell	Y	P	N	S

MOUTH AND THROAT

Frequent sore throat	Y	P	N	S
Canker sores	Y	P	N	S
Breath odor	Y	P	N	S

RESPIRATORY

Cough	Y	P	N	S
Wheezing	Y	P	N	S
Asthma	Y	P	N	S
Bronchitis	Y	P	N	S

BLOOD/PERIPHERAL VASCULAR

Anemia	Y	P	N	S
Easy bleeding/bruising	Y	P	N	S

CARDIOVASCULAR

Heart disease	Y	P	N	S
Murmurs	Y	P	N	S

URINARY

Frequent urination	Y	P	N	S
Bed wetting	Y	P	N	S

GASTROINTESTINAL

Belching/passing gas	Y	P	N	S
Stomach aches	Y	P	N	S
Constipation	Y	P	N	S
Diarrhea	Y	P	N	S
Bowel Movements	How often _____			

MUSCULOSKELETAL

Joint pain/stiffness	Y	P	N	S
Muscle spasms/cramps	Y	P	N	S
Broken bones	Y	P	N	S