ESTABLISHED PATIENT INTAKE FORM

Name of Person Completing Form: _____ Relationship: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Reason for Visit: _____

Is there anything you would like to speak to the provider about **privately**: ☐ No ☐ Yes

Has your child had any **major illnesses** since your last office visit? ☐ No ☐ Yes _____

Has your child had any **surgeries** since your last office visit? ☐ No ☐ Yes _____

Has your child had any **hospitalizations** since your last office visit? ☐ No ☐ Yes _____

Any changes to your **family** history or **social** history in the past year? ☐ No ☐ Yes _____

_____

Please list current medications (including prescribed and/or over the counter):

_____

_____

REVIEW OF SYSTEMS:

Please mark below if your child has experiences any of the following in the past month:

General:
- ☐ Fever: _____
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fatigue

Skin:
- ☐ Rash
- ☐ Swelling
- ☐ Redness
- ☐ Dryness
- ☐ Itching
- ☐ Color change
- ☐ Infection
- ☐ Change in hair/nails

Head:
- ☐ Headache
- ☐ Head injury

Neck:
- ☐ Swollen nodes
- ☐ Stiffness
- ☐ Pain

Eyes:
- ☐ Changes in vision
- ☐ Light sensitivity
- ☐ Pain
- ☐ Redness
- ☐ Drainage

Ears:
- ☐ Ear pain
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Dizziness
- ☐ Discharge

Nose/sinuses:
- ☐ Runny nose/stuffiness
- ☐ Allergies
- ☐ Nosebleeds

Mouth/throat:
- ☐ Sore throat
- ☐ Blisters/sores
- ☐ Thrush

Lungs:
- ☐ Cough
- ☐ Wheezing
- ☐ Difficulty breathing
- ☐ Chest pain

Heart:
- ☐ Murmur
- ☐ Palpitations

Musculoskeletal:
- ☐ Joint pain
- ☐ Stiffness
- ☐ Back pain
- ☐ Muscle pain or cramps

Urinary:
- ☐ Pain
- ☐ Blood in urine
- ☐ Urgency
- ☐ Incontinence
- ☐ Bed wetting
- ☐ Infections
- ☐ Frequency
- ☐ Urinating less
- ☐ Urinating more than normal

Endocrine:
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive sweating
- ☐ Excessive thirst
- ☐ Excessive hunger

Digestion:
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Pain
- ☐ Blood in stool
- ☐ Loss of appetite
- ☐ Overeating

Blood:
- ☐ Easy bruising/bleeding
- ☐ Anemia

Nervous System:
- ☐ Fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness
- ☐ Tremors

Mind:
- ☐ Nervousness
- ☐ Lack of concentration
- ☐ Memory issues
- ☐ Mood swings
- ☐ Depression
- ☐ Excess anger or sadness

☐ Other: _____