JOURNEY OF HEALTH
BLACK BAG MEDICINE

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CHILD INTAKE FORM (0-18 yrs)

Name:_____
Address:_____
City:_____ State ___ Postal Code:_____
Home Phone:_____ Parent/Guardian Cell Phone:_____
Sex:_____ Age:_____ Gestational Age:_____
Height:_____ Weight:_____ Date of Birth:_____
Parent/Guardian Email:_____
Who referred you to us?_____

Pediatrician/Medical Doctor's Name:_____
Pediatrician/Medical Doctor's Phone Number:_____
Pediatrician/Medical Doctor's Address:_____

Who is filling out this form (name and relation)?_____

Reason for coming to office today:_____
_____
_____

Child's Health Concerns, in order of importance:

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

Mother's Profile

Mother's Name:_____
Mother's Age:_____ Present Health Status:_____

Any Prior Medical-Surgical Events (none or list): _____

Are you a smoker? ☐ Yes ☐ No If yes, how many cigarettes per day?_____

Do you consume any alcohol? ☐ Yes ☐ No If yes, how much per week?_____

Are you working presently? ☐ Yes ☐ No ☐ FULL-TIME ☐ PART-TIME

What is your stress level? Please rate on a scale of 1 (least) to 10 (most):_____

Date of Last Menstrual Period: _____

Describe your previous pregnancies (any anxieties, complications):
_____
_____
_____

Prenatal History

Duration of Pregnancy: _____ How was the child conceived? _____

Did you have prenatal medical supervision? □ Yes □ No

List any illnesses, infections, complications during pregnancy:
_____

Treatments/ Medications During Pregnancy (check):

□ Tobacco □ Alcohol □ Recreational Drugs: List _____
□ Prescription/ Over-The-Counter Drugs: _____
□ Supplements/ Others: _____

Did you take Prenatal Classes? □ Yes □ No
Planned or unplanned pregnancy? _____
Helping persons available during pregnancy: _____

Describe your diet during the pregnancy. Indicate cravings also.
_____
_____
_____

How much weight did you gain? _____

Did you experience any of the following (check):

□ nausea □ vomiting □ high blood pressure □ diabetes
□ physical or emotional trauma
□ other _____

Describe your reaction when you first felt the baby move.
_____

Any past miscarriages? □ Yes □ No If yes, when:_____

Labor and Delivery History

Birth Weight:_____ Birth Height:_____
Duration of Labor: _____
Type of Delivery (natural vaginal / C-section):_____
Medications and Anesthesia (types, durations, any reactions):
_____

Were any of the following used?

□ episiotomy □ forceps □ vacuum □ epidural □ other: _____
Any complications (none or list)? _____
Fluids-blood loss (how much): _____
Attended by significant other? □ Yes □ No
Held and/or nursed baby on delivery table? □ Yes □ No
APGAR score:_____
Any congenital abnormalities (none or list):_____

Father's Profile

Father's Name:_____

Father's Age:_____ Present Health Status:_____

Any Prior Medical-Surgical Events (none or list): _____

Are you a smoker? □ Yes □ No If yes, indicate how many cigarettes per day: _____

Do you consume any alcohol? □ Yes □ No If yes, indicate how much per week: _____

Are you working presently? □ Yes □ No □ FULL-TIME □ PART-TIME

What is your stress level? Please rate on a scale of 1 (least) to 10 (most):_____

Child's Profile

A. Medical History:

Any medical conditions (illnesses, injuries, etc.) (If in past, please provide date):

past _____ present _____

_____ _____

_____ _____

Childhood Illnesses:
If child has had any of the following in the past, please provide date of occurrence.

Name	**Date**
Rubella	
Measles	
Mumps	
Roseola	
Chicken Pox	
Strep Throat	
Rheumatic Fever	
Scarlet Fever	
Impetigo	
Ear Infections (also state how often)	

Current and Past Medications and/or Supplements (indicate brand and dose, for how long):

_____
_____
_____
_____

Vaccination History (check and provide date):

□ DPT (diphtheria, pertussis, tetanus), when: _____
□ Tetanus booster, when: _____
□ MMR (measles, mumps, rubella), when: _____
□ Polio, when: _____
□ Flu shot, when: _____
□ Haemophilus influenza B, when: _____
□ Hepatitis A, when: _____
□ Hepatitis B, when: _____

□ Others: _____
List any adverse reactions:
_____
_____

Accidents and injuries (what and when):
_____
_____
_____

Hospitalizations and surgeries (for what reason and when):
_____
_____
_____

Does your child have any allergies? (medicines, environment, etc.)
_____
_____
_____

B. Feeding/ Nutritional History:

- breastfed for how long:_____
- formula at what age: _____
- what kind of formula (milk, soy, other): _____
- reactions to any formulas? □ Yes / No □ If yes, describe: _____

Food Introduction Schedule:
- list foods that were introduced and at which month:

Age of Food Introduction							
Type of Food Introduced							

Diet:

Describe your child's appetite:
_____
_____

Please give a 24-hr diet recall for the child:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Cups of water drank in a day: _____

Food preferences and dislikes? _____

C. Sleeping Patterns:

When does the child go to bed? _____ When does he/she wake up? _____
Does the child wake up in the night? □ Yes □ No If yes, how often: _____
Does your child take naps? □ Yes □ No If yes, how long are naps: _____

D. Developmental milestones:
When did child first: sit up _____ crawl _____ walk _____ talk _____
be fully toilet- trained _____ brush own teeth _____

E. Family History (include chronic, inherited conditions, allergies, causes of death, illnesses):

Relative	*Condition(s)*
Mother	
Father	
Sibling #1	
Sibling #2	
Sibling #3	
Sibling #4	
Grandparents	
Other	

F. Psychosocial/ Overall Health:
Child's Hobbies and Enjoyed Activities:
_____
_____
_____
How often does your child watch TV/ play video games? (check day or week) _____ hrs a □ day / □ week
Is your child in (check): □ school □ daycare □ other _____
Current School: _____
Grade: _____
How would you describe your child's performance and behaviour at school?
_____
Does your child exercise regularly? □ Yes □ No If yes, what type of exercise, how much and how often:
_____

Home/ Environment Profile

Describe home preparations made for the new baby.
_____
_____

Describe how bringing home a new baby changed the life of each member of the family.
_____
_____
_____
Position of child in family: _____
Number of people in the home: _____

Who is the primary caregiver(s)? _____
Other caretakers for child: _____
Does anyone in the home smoke? □ Yes □ No
Do you know of any toxins or hazards that your child is exposed to regularly (home, hobbies, etc.)?
_____
_____
Any pets in the home? □ Yes □ No If yes, list: _____

How old is the house the family is living in? _____
Has it been recently renovated? □ Yes □ No

Review of Systems

Circle the symptoms child has experienced check *N* if currently experiencing it or *P* if in past.

General: headache □P □N; fever/ chills □P □N; fatigue/ weakness □P □N; dizziness □P □N

Hair and Scalp: dandruff □P □N; lice □P □N; cradle cap □P □N; itchiness □P □N; hair loss □P □N

Skin: infections □P □N; rashes □P □N; scaling □P □N; bruising □P □N; bleeding □P □N

Eyes: infections □P □N; blurred vision □P □N; eyeglasses (nearsighted, farsighted) □P □N

Squinting □P □N; color blindness □P □N

Ears: infection □P □N; discharge □P □N; wax □P □N; decreased hearing □P □N; foreign objects □P □N

Nose, throat, sinuses: runny nose □P □N; colds □P □N; decreased smell □P □N; foreign objects □P □N; bloody nose □P □N

Tonsillitis □P □N

Mouth and dentition: caries □P □N; gingivitis □P □N; cleft lip □P □N; palate □P □N

Respiratory: bronchitis □P □N; pneumonia □P □N; asthma □P □N; cough □P □N; sputum □P □N

Cardiovascular: heart murmurs □P □N; cyanosis □P □N; palpitations □P □N; rheumatic fever □P □N

Gastrointestinal: nausea □P □N; vomiting □P □N; diarrhea □P □N; constipation □P □N; jaundice □P □N

colic □P □N; gas □P □N; anorexia □P □N; blood in stool □P □N

Urinary: increased frequency □P □N; urgency □P □N; burning □P □N; bedwetting □P □N

odor □P □N; blood in urine □P □N; hesitancy □P □N

Male Reproductive: hernias □P □N; testicular mass □P □N; testicular pain □P □N; penile discharge □P □N

Female Reproductive: menses □P □N; vaginal itching □P □N; vaginal discharge □P □N

Neuromuscular: seizures □P □N; muscle weakness □P □N; numbness □P □N; tremors □P □N; imbalance □P □N

Blood/ Lymphatics: anemia □P □N; easy bleeding □P □N; easy bruising □P □N; swollen lymph node □P □N

Emotional: mood swings □P □N; nervousness □P □N; depression/ sadness □P □N

ADOLESCENCES ADDENDUM (13- 18 yrs)

To be filled out by patient if between the age of 13-18.

Medical History:

What are your health concerns, in order of importance?

1)_____
2)_____
3)_____
4)_____

Do you do/ take any of the following (check)?

□ smoke, if so, how many packs per (circle) day / week _____
□ alcohol, if so, how much and how often _____
□ recreational drugs, if so, how much and how often _____
□ others _____

Psychosocial:

How would you describe your

- relationship with parents:	□ Excellent	□ Good	□ OK	□ Poor
- relationship with siblings:	□ Excellent	□ Good	□ OK	□ Poor
- relationship with friends:	□ Excellent	□ Good	□ OK	□ Poor

Do you enjoy school? □ Yes □No

What do you like/ dislike about school?

_____What is your stress level? Please rate on a scale of 1 (least) to 10 (most) for the following:

Home: _____ School: _____ Other (list): _____

List extra-curricular activities and hobbies: (sports teams, bands, piano lessons, etc.):

_____

_____

List your goals (future goals, career, etc.):

_____

How much TV do you watch? (check day or week) _____ hrs a □ day / □ week
How often do you play video games? _____ hrs a □ day / □ week
How often do you use the internet/ computer? _____ hrs a □ day / □ week
Do you exercise? Yes / No If yes, what type of exercise, how much and how often:

_____

MALE

Age of onset of puberty: _____
Have you noticed any change in the penis and scrotum? _____
Are you familiar with normal growth patterns, nocturnal emissions ("wet dreams"), and sex education?

_____

FEMALE

When did you notice your breasts were changing? _____
How old were you when you had your first period? _____
Average # of bleeding days (period) _____ Average # of days between bleeding _____
Is there bleeding between periods? _____

Sexual History:

Are you sexually active? □ Yes □ No If yes, please continue.
What type of birth control do you use (none or list)?

_____

Have you been tested for STD's/ venereal diseases? □ Yes □ No If yes, which ones?

_____

Sexual Preference (check mark): □ Heterosexual □ Bisexual □ Homosexual
Female: When was your last PAP test? _____
Female: Have you ever been pregnant, had a live birth, miscarriage or abortion?

_____

Is there anything you feel is important that has not been addressed?