

Metamorphe Health Clinic
3976 E. Harbor Road
Langley, WA 98260
360-221-2050

Mailing address:
P. O. Box 1072
Freeland, WA 98249

Confidential Pediatric Intake form to be filled out by parent or legal guardian.

Today's Date: _____

Child's Full Name: _____

Prefers to be called: _____

Date of Birth _____ Sex: male _____ female _____

Date of last complete check up: _____

Height _____ Weight _____

Major Complaint: What brings you in for this initial visit? If a diagnosis was made, please indicate date of diagnosis and who or where it was diagnosed.

Are there any areas you would like to work on?

How would you rate the General Health of your child: (1 being Poor; 10 being Excellent):

Poor 1 2 3 4 5 6 7 8 9 10 Excellent

Is your child on any Medications, Homeopathics, or Supplements (including vitamins and herbs)? Please list dosages.

List Allergies to medications?

Medication and Reaction:

Allergies to other substances (foods, inhalants, etc):

Any difficulties for child following childbirth?

Has your child experienced any major childhood illnesses/diseases, accidents, hospitalizations, or surgeries? (Please include approximate dates and child's age at time)

Immunizations and date if known:

DTP _____ Polio _____
MMR _____ Hepatitis B _____
HbCV _____ Chickenpox _____
Other _____

Siblings:

Name _____ Age ____ General Health: ____ Poor ____ Fair ____ Good
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What are some of your child's favorite activities/hobbies?

Does your child have any fears?

What are your child's favorite foods and how often are they eaten?

What type of pets do you have?

Does anyone in the house smoke? ____ YES ____ NO

How many hours of TV and video/computer games does your child engage in daily? _____

How would you rate your child's academic performance? (if appropriate) ____ Poor ____ Fair ____
Good ____ Excellent

Is there anything else you feel the doctor should know about your child?

Family Medical History:

Check all that apply and indicate family member's relation to child (ie: maternal aunt). If family member has passed away from any of the following, please indicate their approximate age at the time of their passing.

____ Diabetes _____

____ Heart Disease _____

____ Stroke _____

____ Heart attack _____

____ Thyroid Disorders _____

____ Alzheimer's disease _____

____ Other neurological disease (indicate) _____

____ Hypertension _____

____ High Cholesterol _____

____ Osteoporosis _____

____ Cancer (type) _____

____ Chronic Gastrointestinal Disease (ie: Crohn's disease, Celiac, Ulcerative Colitis, Peptic Ulcers, Reflux) _____

____ Asthma _____

____ Emphysema (or other chronic respiratory disorder) _____

____ Chronic skin condition (ie: Psoriasis, eczema, rosacea) _____

____ Depression _____

____ Alcoholism _____