

Pediatric Intake form for Pacific Allergy and Wellness

For Infants and Children 6 months to 6 Years

Childs Name: _____ Date: _____

Parents/ Guardian Name: _____

Childs Date of Birth (M/D/Y): _____ Current Age: _____

How were you referred?

- | | | |
|--|---|---|
| <input type="checkbox"/> Brochure | <input type="checkbox"/> Magazine Ad/ Article | <input type="checkbox"/> Friend & Name: _____ |
| <input type="checkbox"/> Website / Online search | <input type="checkbox"/> Health Show | <input type="checkbox"/> Other _____ |

What problem brings your child to this appointment?

When did your child's symptoms begin? _____

Are your child's symptoms getting worse? Circle: Yes or No

Does you infant/ child have any of the following symptoms? Please check all that apply

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Chest Tightness | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Snoring | <input type="checkbox"/> Itchy Nose | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Headaches | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Itchy/ Watery Eyes | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Hives/ Swelling | <input type="checkbox"/> Change in Appetite |
| <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> Blocked Ears | <input type="checkbox"/> Rashes | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Runny Nose | <input type="checkbox"/> Body/ Breath Odor | <input type="checkbox"/> Aggression | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Sinus Infection | <input type="checkbox"/> Eczema | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Frequent vomiting |
| <input type="checkbox"/> Sputum/ Phlegm: Color _____ | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Stomach aches | |

Which of the following trigger (or cause) the symptoms? Please check all that apply

- | | | | |
|-------------------------------------|--|--|--|
| <input type="checkbox"/> Grass | <input type="checkbox"/> Cats | <input type="checkbox"/> Cold Air | <input type="checkbox"/> Pollution |
| <input type="checkbox"/> Hay | <input type="checkbox"/> Dogs | <input type="checkbox"/> Humidity | <input type="checkbox"/> Swimming pools |
| <input type="checkbox"/> House Dust | <input type="checkbox"/> Horses | <input type="checkbox"/> Mold & Mildew | <input type="checkbox"/> Weather Changes |
| <input type="checkbox"/> Leaves | <input type="checkbox"/> Other Animals | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Other: _____ |

When are your child's symptoms worse?

- | | | | |
|---------------------------------------|-----------------------------------|---------------------------------|------------------------------------|
| <input type="checkbox"/> Morning | <input type="checkbox"/> January | <input type="checkbox"/> May | <input type="checkbox"/> September |
| <input type="checkbox"/> Daytime | <input type="checkbox"/> February | <input type="checkbox"/> June | <input type="checkbox"/> October |
| <input type="checkbox"/> Evening | <input type="checkbox"/> March | <input type="checkbox"/> July | <input type="checkbox"/> November |
| <input type="checkbox"/> Varied times | <input type="checkbox"/> April | <input type="checkbox"/> August | <input type="checkbox"/> December |
| <input type="checkbox"/> Year round | | | |

Has your child ever been skin tested or had a blood test for allergies? Circle: Yes or No

(*If yes, please bring copies of the results.)

Has your child ever had allergy injections? Circle: Yes or No If yes, when: _____

Do you carry an EpiPen for your child? Circle: Yes or No

Immunizations (Check the ones your child has had)

- | | |
|---|--|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles, Mumps, Rubella (MMR) |
| <input type="checkbox"/> Diphtheria, Pertussis, Tetanus (DPT) | <input type="checkbox"/> Meningococcal Conjugate |
| <input type="checkbox"/> H1N1 | <input type="checkbox"/> Pneumonococcal Conjugate |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Rotavirus |
| <input type="checkbox"/> HIB Haemophilus Influenza | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Influenza/ Flu shot | <input type="checkbox"/> Small Pox |
| <input type="checkbox"/> Other: _____ | |

Any comments on immunizations not given in usual frequency:

General information:

Any known Food Intolerances/ Allergies: _____

Feeding:

- Breast Fed How long did you breast feed? _____
- Formula Milk (Cow) Soy Other

Name of formula used: _____

(*Please bring the container to appointment)

Age began solid foods: _____

Diet in a typical day:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Fluids: _____

Number of pets? _____ Indoor Outdoor Dog Cat Birds Other: _____

Has your child had their tonsils or adenoids removed? Circle: Yes or No

Has your child had ear surgery? Circle: Yes or No If yes. Please explain: _____

Was your child born via: Caesarean Section or Vaginal birth

Childhood Illnesses: Check all that apply

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Ear infection | <input type="checkbox"/> Mumps | <input type="checkbox"/> Rubella | |

Family History:

Who in your family has had any of the following:

Asthma: _____ Eczema: _____

Arthritis: _____ Heart Disease: _____

Diabetes: _____ Sinus Problems: _____

Seasonal or year round allergies: _____

Other allergies (Drugs, bees, food, etc.): _____

Please briefly list any hospitalizations your child has had regardless of cause:

List any food allergies and reactions experienced:

List any drug, chemical or environmental allergies and reactions experienced:

List all medications and dosages (Including nasal sprays, non allergy medications and alternative or herbal products):

Food allergy Section:

Check any symptoms that your child has exhibited:

- | | |
|--|---|
| <input type="checkbox"/> Anaphylactic reaction | List causative item if known: _____ |
| <input type="checkbox"/> Abdominal cramping | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Canker sores | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Itching (Skin or rectal) |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Diarrhea or loose stools | <input type="checkbox"/> Red rash around mouth, reddening /swelling of skin |
| <input type="checkbox"/> Difficulty Concentrating | <input type="checkbox"/> Rhinitis |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Runny nose |
| <input type="checkbox"/> Emotional upset | <input type="checkbox"/> Stomach ache |
| <input type="checkbox"/> Excessive regurgitation | <input type="checkbox"/> Swelling of lips or face |
| <input type="checkbox"/> Food cravings | List foods: _____ |
| <input type="checkbox"/> Fatigue or sudden drops in energy after meals | <input type="checkbox"/> Swelling of the joints |
| <input type="checkbox"/> Gas or Bloating | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Wheezing |

Miscellaneous:

Indicate any additional information about your child's symptoms of allergy or health that may be helpful:
