Family Health Care
Pediatric Intake Form

CHILD'S NAME:_____**TODAY'S DATE:**_____
DATE OF BIRTH:_____

Our practice is dedicated to providing the best possible care for your child. In order for us to serve you better, please take a few minutes to answer the following questions. Your answers will be kept strictly confidential.

Circle either the word or the letter for your answer where appropriate. Fill in answers where space is provided.

Relationship to Patient?
A. Mother D. Foster parent
B. Father E. Other relative
C. Grandparent F. Other

How many times have you moved in the last year?
_____ times

Where is your child living now?
A. House or apartment with family C. Shelter
B. House or Apartment D. Other
Has your child received health care elsewhere? Yes No
If yes, what?_____

How would you rate this child's health in general?
A. Excellent B. Good C. Fair D. Poor
Do you have any concerns about your child's behavior or development? Yes No
If yes, what?_____

What are your main concerns about your child?
_____

How old are you?_____

Are you: A. Single B. Married
C. Separated D. Divorced E. Other

What is the highest grade you have completed:
1 2 3 4 5 6 7 8 9 10 11 12 High School GED
Some college or vocational school College graduate Postgraduate

Family Health Habits
How often does your child use a seatbelt (Car seat)?
A. Never B. Rarely C. Sometimes D. Often E. Always

Does your child ride a bicycle? Yes No
If yes, how often does he/she use a helmet?
A. Never B. Rarely C. Sometimes D. Often E. Always

Do you feel that you live in a safe place? Yes No
Threatened in your home? Yes No
In the past year, has your partner or other family member pushed you, punched you, kicked you, hit you, or threatened to hurt you? Yes No

What kind of guns are in your home? A. Handgun
B. Shotgun C. Rifle D. Other_____ E. None
If you have a gun at home, is it locked up? Yes No

Does anyone in your household smoke? Yes No
Do you currently smoke cigarettes? Yes No
If yes, how many cigarettes do you smoke per day?_____