

Charleston Pain Relief Center
2294 Otranto Road
North Charleston, SC 29406
(843)225-2550 fax (843)225-2590

Pediatric Intake Information (Confidential):

Name _____
Date ____/____/____ S/S ____ - ____ - ____
Birth Date ____/____/____ Current: Height _____ Weight _____ Female Male
Parent/Guardian Name _____
Address _____ City _____
State ____ Zip _____ Home Phone _____
Work Phone _____ Cell Phone _____
Who may we thank for referring you to us?

HEALTH HISTORY

Does your child currently have or have they previously had any of the following symptoms:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Colic | <input type="checkbox"/> Excessive Spitting up |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Fainting | <input type="checkbox"/> Allergies | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Fever | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Cold Hands <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Upset Stomach | <input type="checkbox"/> Light Sensitivity to Eyes | <input type="checkbox"/> Ringing/ Buzzing in Ears | |
| <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Low Back Pain |

Chief Health Concerns:

List other types of Care undergone for this complaint (including medications):

Date of onset: _____: Sudden Gradual Associated with an event

Duration of problem (episode): _____ How often do you notice the symptoms? Constantly Frequently Occasionally

Does anything alleviate the symptoms? _____ Is the condition getting worse? No Yes

Effects of problems on body function and daily activities: _____

Was there an injury or fall? No Yes,

Describe _____

Have you had x-rays before? No Yes, When? _____

What areas? _____

List any other concerns:

History of Birth:

Hospital Birthing Center Home Midwife Birth Weight: _____

Duration of Gestation: _____ weeks

Was the birth assisted? No Yes, if Yes: forceps vacuum c-section induced labor

Evidence of Birth Trauma? (i.e., bruises, odd shaped head, stuck in birth canal, fast or excessively long labor, respiratory depression, cord around neck)

Medication delivered to mother at birth? No Yes, what?

Duration of labor: _____

Complications at birth: No Yes, explain:

Growth and Development:

Was the infant alert and responsive within twelve hours of delivery? No Yes If No,

Explain: _____

At what age did the child: Hold head up: _____ Sit alone: _____ Crawl: _____

Walk: _____

Do your child's sleeping patterns seem normal to you: Yes No,

Chemical Stressors:

Was (is) the baby breast-fed? Yes, for how long? _____ No, explain reason

Formula introduced at age: _____ Type of formula used:

Cow's milk introduced at age: _____ Began solid food at age: _____ Type:

Food/Juice intolerance: No Yes, type:

During pregnancy did the mother: Smoke? No Yes Drink Alcohol? No Yes

Supplements taken during pregnancy:

None

Drugs taken during pregnancy:

None

Any other complications during pregnancy:

None

Has your child received vaccinations: No Yes, which ones and reactions

Has your child received antibiotics: No Yes, Total courses of antibiotics to date

Current medications and reasons:

None

Surgical History:

None

DATE: ____/____/____ **PARENT/ GUARDIAN**

Signature: _____