



Soaring Crane Natural Health Center

209 W Cedar Ave. Palmer, AK 99645. 907.745.3999. soaringcraneclinic.com

Pediatric Intake Form (0-12 years)

Name _____ Age _____ Date _____
Date of Birth _____ Birth Weight _____ Sex _____ Race _____

Mother's name _____ Father's name _____
Address _____
City _____ State _____ Zip _____
Telephone # (home) _____

How did you hear about this clinic? _____

Health Insurance: Company _____
Policy/ID # _____ Group/code # _____
Name policy is in _____

Health History Questionnaire

What are your child's most important health problems? List as many as you can in order of importance.

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

What has already been done for the above mentioned problems (not applicable for a well-child visit)?

Does your child have a contagious disease at this time? y n
If yes, what? _____

Birth History

List major patterns of illness present in the child's birth mother, father or their families:

Did mother receive prenatal care? ___ Prenatal vitamins? ___ Medications (type)? ___
Did mother smoke cigarettes? ___ Drink alcohol? ___ Illicit Drugs (type)? ___

Any difficulties with the pregnancy (nausea, vomiting, bleeding, etc):

Type of birth (eg. hospital, home, C-section) _____ Carried to term? ___
If no, how premature? _____ Complications of labor or delivery: _____



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Typical Food Intake

Breakfast: _____
 Lunch: _____
 Dinner: _____
 Snacks: _____
 To Drink: _____

Please list any prescription medications, over the counter medications, vitamins or other supplements your child is taking.

1) _____ 4) _____
 2) _____ 5) _____
 3) _____ 6) _____

Habits:

Does your child watch tv? Y N How many hours per day? _____
 Does your child read? Y N How many hours per day? _____
 Play video games? Y N How many hours per day? _____
 Does your child do sports? Y N How many hours per week? _____
 Day care/School/Home School (circle) Grade level? _____
 What are your child's favorite activities? _____
 Anyone in your house smoke? Y N
 Are there pets in the home? Y N What kind? _____

Social History

Whom does the child live with? _____ Are parents divorced/separated?
 If so, what if any arrangements are made with the other parent (eg. visitation)? _____

List age and gender of siblings; indicate half, step or deceased where applicable.

Any pregnancies not carried to term? _____

Environmental

What type of dwelling do you live in? _____ How old? _____
 Water supply? _____ Type of heat? _____

Any difficulties with school (describe):

How would you describe the child's...

Personality? _____

Intelligence? _____

Temper? _____

Sociability? _____



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Describe problems in the following areas:

Digestion: _____

Skin: _____

Respiratory: _____

Urinary: _____

How much sleep does he/she get? From _____ pm to _____ am quality? _____

Was this child early or late in rolling over, teething, talking? _____

Anything not covered in this questionnaire that you feel is important for your doctor to know about?

Thank you! We look forward to working with you and your family. Please feel free to ask any questions along the way. We are happy to recommend other resources to promote healthy families and community.

The docs at Soaring Crane Natural Health Center.