Pediatric Intake Form

Wareham Pediatrics
Boston Children's
Primary Care Alliance
warehampeds.com
508-295-8622

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 as part of your child's medical record. Ongoing evaluations of our care may involve chart reviews by qualified persons, but neither your name nor your child's name will ever appear in any reports.

Child's Name: _____
Today's Date: _____

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

Are you the child's
A. Mother B. Father C. Grandparent D. Foster Parent
E. Other relative F. Other _____ G. Self (Are you the patient?)

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

Where is the child living now?
A. House or apartment with family B. House or apartment with relative or friends
C. Shelter D. Other

Besides you, does anyone else take care of the child? Yes No
If yes, who? _____

Has the child received health care elsewhere? Yes No
If yes, what? _____

Has the child received any immunizations? Yes No
Which ones? _____
Where? _____

Has the child ever been hospitalized? Yes No
When? _____
Where? _____
Why? _____

How would you rate this child's health in general?
A. Excellent B. Good C. Fair D. Poor

Do you have 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? _____ years old

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

What is the highest grade you completed? none
1 2 3 4 5 6 7 8 9 10 11 12 (High School/GED) Some college or vocational school
College graduate Postgraduate

Family Medical History

Do the child's mother, father, or grandparents have any of the following? If yes, who?

Yes ○	No ○	High Blood Pressure	
Yes ○	No ○	Diabetes	
Yes ○	No ○	Lung Problems (asthma)	
Yes ○	No ○	Heart Problems	
Yes ○	No ○	Miscarriages	
Yes ○	No ○	Learning Problems	
Yes ○	No ○	Nerve Problems	
Yes ○	No ○	Mental illness (depression)	
Yes ○	No ○	Drinking Problems	
Yes ○	No ○	Drug Problems	
Yes ○	No ○	Other	

Family Health Habits

How often does your child use a seatbelt (carseat)? Never

A. Never B. Rarely C. Sometimes D. Often E. Always

Does your child ride a bicycle? No Yes No

If yes, how often does he/she use a helmet? Never

A. Never B. Rarely C. Sometimes D. Often E. Always

Do you feel that you live in a safe place? Yes ○ No ○

In the past year, have you ever felt 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? none

A. Handgun B. Shotgun C. Rifle D. Other _____ E. None

If you have a gun at home, is it locked up? N/A ○ Yes ○ No ○

Does anyone in your household smoke? Yes ○ No ○

If yes, how many cigarettes do you smoke per day?

_____ cigarettes per day