Initial Intake Form

Today's Date: ___________

Hornet Health Clinic
412 Woodland Dr
Bryant, AR 72022
501-653-5040

Patient Name: ______________________________ DOB: _____/_____/________ Male / Female Age:__________

Name of person completing form: ____ Relationship to patient: _________________

Is your child presently taking any medications? YES NO

If yes, please list with dosage and prescribing physician's name: ____

____

BIRTH HISTORY

HOSPITAL: ____

Birth Weight _____lbs ___oz

Term or Premature (_______wks) Vaginal birth or c-section

If Yes (details) ___________________________ Blood type ___________

Complications	Yes	No			
Hearing screen passed	Yes	No	Not Known		
First Hep B given	Yes	No			
Circumcision	Yes	No	N/A	When_______	Details ____
Hospitilization	Yes	No		When_______	Details ____
Surgeries	Yes	No		Details ____	

Does your child have a history of any of the following problems?

Developmental Delay	ADD/ADHD	Cerebral Palsy	Prematurity
Allergic Rhinitis / Hay Fever	Diabetes	Ear Infections	PT / OT / Speech Therapy
Asthma/Wheezing	Eczema	Seizure Disorder	NONE OF THESE
Behavior/Emotional Problems	GE Reflux	Urinary Tract Infections	

FAMILY HISTORY Have any family members (including natural parents, grandparents, aunts, uncles, siblings) had any of the following?

Heart Disease < 55 yrs	High Cholesterol	Allergies	ADD / ADHD	Mental Health Issues
Seizure Disorder	Diabetes	Asthma	Substance Abuse	

Additional Family History: ____

SOCIAL HISTORY Please list all those living in the child's home.

Name	Relationship to child	Birthdates	Health Problems

What is the parent's marital status? Single Married Divorced Unmarried/Living Together

Does anyone in the home smoke? YES NO

If yes, who in the home smokes? ____