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naturopathic medicine

PEDIATRIC INTAKE FORM (6-12 YEARS)

Patient's Name: _____ Date: _____

Age: _____ Date of Birth: _____ Gender: Female / Male

Parent/Guardian's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone (home or cell): _____ (Parent's work): _____

Parent's email address: _____

How did you hear about this clinic? Another practitioner _____ ND directory _____

Friend/family member _____ Google search Brochure/Business Card

Public Presentation Professional Seminar Other _____

Has any other family member already been a patient at this clinic?_____

Name of doctor's office/hospital/clinic where your child's health records are kept: _____

_____

Reason for referral or presenting problems:_____

_____

_____

HEALTH HISTORY QUESTIONNAIRE

Birth city & state: _____ Birth time: _____ Birth weight:_____

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

1._____

2._____

3. _____

4. _____

5. _____

Does your child have a contagious disease at this time? Y N

If yes, what? _____

_____

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FAMILY HISTORY

____ Heart disease ____ Diabetes ____ Birth defects
____ Hypertension ____ Arthritis ____ Tuberculosis
____ Cancer ____ Allergies ____ Asthma
____ Mental illness ____ Osteoporosis ____ other significant: _____

_____

_____

MEDICAL HISTORY

____ Chicken pox ____ Scarlet fever ____ Tonsillitis, approx no. of times: _____
____ Measles ____ Pneumonia ____ Ear infections, approx no. of times: _____
____ Mumps ____ Frequent colds ____ Strep throat, approx no. of times: _____
____ Rubella ____ Rheumatic fever ____ Other: _____

Has your child had any of the following tests? **When** **Where** **Results**

Electroencephalogram (EEG)_____

Psychological evaluation_____

Hearing tests_____

Speech/Language tests_____

HOSPITILIZATIONS/SURGERIES/INJURIES

What hospitalizations, surgeries or injuries has your child had?

_____

_____

IMMUNIZATIONS

____ MMR ____ DPT ____ Chicken pox Others:_____
____ Measles ____ Diphtheria ____ Small pox Adverse reactions: Y / N
____ Mumps ____ Tetanus ____ H. influenza If so, what? _____
____ Rubella ____ Polio ____ The flu _____

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ALLERGIES

Is your child hypersensitive or allergic to:

Any drugs?_____

Any foods? _____

Any environmentals?_____

Breast fed? _____ how long? _____ Formula? _____ milk / soy _____

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)_____ 5)_____

2)_____ 6)_____

3)_____ 7)_____

4)_____ 8)_____

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REVIEW OF SYSTEMS

Y = a condition now **P** = significant problem in the past **N** = never had

MENTAL/ EMOTIONAL

Mood Swings	Y	P	N
Irritability	Y	P	N
Hyperactivity	Y	P	N
Introvert/extrovert	Y	P	N
Motion/car sickness	Y	P	N
Anxiety/nervousness	Y	P	N
Cries easily	Y	P	N
Unusual fears	Y	P	N
Sleep problems	Y	P	N
Nightmares	Y	P	N

ENDOCRINE

Heat/cold intolerance	Y	P	N
Fatigue	Y	P	N
Excessive thirst	Y	P	N
Excessive hunger	Y	P	N
Low blood sugar	Y	P	N
High blood sugar	Y	P	N

SKIN

Rashes	Y	P	N
Eczema, Hives	Y	P	N
Acne, Boils	Y	P	N
Itching	Y	P	N

HEAD

Headaches	Y	P	N
Head Injury	Y	P	N
Dizzy spells	Y	P	N
High fevers	Y	P	N

EYES

Glasses or contacts	Y	P	N
Tearing or dryness	Y	P	N
Eye pain/strain	Y	P	N

EARS

Earaches	Y	P	N
Impaired hearing	Y	P	N

NOSE AND SINUSES

Frequent colds	Y	P	N
Nose Bleeds	Y	P	N
Stuffiness	Y	P	N
Hayfever	Y	P	N
Sinus problems	Y	P	N
Loss of smell	Y	P	N

MOUTH AND THROAT

Frequent sore throat	Y	P	N
Canker sores	Y	P	N
Breath odor	Y	P	N

RESPIRATORY

Cough	Y	P	N
Wheezing	Y	P	N
Asthma	Y	P	N
Bronchitis	Y	P	N

CARDIOVASCULAR

Heart disease	Y	P	N
Murmurs	Y	P	N

URINARY

Frequent urination	Y	P	N
Bed wetting	Y	P	N

GASTROINTESTINAL

Belching/passing gas	Y	P	N
Stomach aches	Y	P	N
Constipation	Y	P	N
Diarrhea	Y	P	N
Bowel Movements	How often ____		

MUSCULOSKELETAL

Joint pain/stiffness	Y	P	N
Muscle spasms/cramps	Y	P	N
Broken bones	Y	P	N

BLOOD/PERIPHERAL VASCULAR

Anemia	Y	P	N
Easy bleeding/bruising	Y	P	N

Is there any information about your child's health that you would like to add?

What expectations do you have for your child from working with our clinic?

Welcome! We're honored to be of service for you and your child!