NATUROPATHIC WOMENS WELLNESS

PEDIATRIC INTAKE FORM

Patient's Name: ____ Date: ______________

Age: ________ Date of Birth: _________ Gender: Female / Male. Height_______Weight_________

Parent/Guardian's Name: ____

Address: ____

City: _________________________________ State: ______________ Zip: __________________

Telephone (home/cell): _________________________ (Parent's work):______________________

Parent's email address: ____

How did you hear about this clinic? ____

Has any other friend or 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: ____

Would you like to receive our email newsletter for articles, news, events, and discounts? ___________

What method(s) can we use to contact you? cell phone ____ home phone ____ e-mail ____ mail _____

MEDICATIONS

NOW	PAST		NOW	PAST		NOW	PAST	
____	____	Aspirin	____	____	Decongestants	____	____	Ibuprofen
____	____	Tylenol	____	____	Anti-histamine	____	____	Antibiotics

____ ____ Other __________________________ Allergies to medicines: ______________________

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 ever had any of the following? WHEN WHERE RESULTS

Electroencephalogram (EEG): ____

Psychological evaluations:____

Hearing test: ____

Speech/language tests: ____

Injuries/surgeries/hospitalizations (please list): _______________________________________

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NATUROPATHIC WOMENS WELLNESS

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 __________________________

FAMILY HISTORY

____ Heart disease ____ Hypertension ____ Cancer ____ Mental illness

____ Diabetes ____ Arthritis ____ Allergies ____ Osteoporosis

____ Birth defects ____ Tuberculosis ____ Asthma ____ Other ______

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications? ________________________________

Mother's age at child's birth: ______

Mother's health during pregnancy:

____ Bleeding ____ Nausea ____ Hypertension ____ Diabetes

____ Physical or emotional trauma ____ Illnesses ____ Thyroid problems

____ Cigarettes, alcohol, drug consumption ____ Medications

BIRTH HISTORY

Term: ______ Full____ Premature____ Late Length of labor: _______ Complications:________

Birth city & state: _______________________________________ Birth weight:_____________

Did you child have any of the following problems shortly after birth?

____ Rashes ____ Birth injuries ____ Blue baby ____ Jaundice

____ Seizures ____ Cerebral palsy ____ Colic ____ Fever

____ Birth defects Other: ____

Child's sleep patterns (1st year): ____

Food intolerances: ____

Breast fed: Y / N How long: __________ Formula: Y / N Type (milk, soy):_______________

Age began solids: _________ Which foods:____

Age began: Sitting _______ Crawling _______ Walking _______ Talking ________

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SYMPTOMS

____ Hives
____ Burning urine
____ Bloody urine
____ Eczema
____ Cries easily
____ Bleeding gums
____ Heart murmur
____ Nervous
____ Nose bleeds
____ Vomiting spells

____ Night sweats
____ High fevers
____ Jaundice
____Sensitive to light
____ Chronic rash
____ Stomach aches
____ Diarrhea
____ Hearing loss
____ Easy bruising
____ Acne

____ No appetite
____Body/breath odor
____ Constipation
____ Nightmares
____Frequent colds
____Bleeding tendency
____Unusual fears
_____Wheezing
_____Cough
_____Sleep problems

____ Asthma
____Excessive fatigue
____ Flat feet
____ Hair loss
____ Allergies
____Frequent urination
____ Anemia
____ Dizzy spells
____ Sore throats
____ Joint pains

TYPICAL DIET

Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____
To drink: ____

THANK YOU. WE LOOK FORWARD TO HELPING YOU.

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