

Pediatric / Adolescent Intake Form

Today's Date _____

Name _____ Birthday _____ Age _____ Sex _____

Address _____ City/State/Zip _____

Parent/Guardian 1 name _____ Parent/Guardian 2 name _____

Phone-Hm _____ Phone-Wk _____ Parent 1 Cell _____ Parent 2 Cell _____

What other Health Care are you presently receiving? _____

Primary Health Care Provider _____ Phone _____

Permission to consult with primary provider? Please initial if yes. Yes No

Person to contact in case of emergency _____ Phone _____

How did you hear about our clinic? _____



A NOTE TO OUR PATIENTS: Naturopathic, holistic, and preventive health care are only possible when the physician has a complete profile of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible.

PLEASE LIST THE HEALTH CONCERNS/PROBLEMS THAT BRING YOU IN TODAY:

1) _____

2) _____

HISTORY OF THESE CONCERNS/PROBLEMS:

Has the child received any treatment for this ailment?

1) yes no If yes, what? _____

2) yes no If yes, what? _____

Has the child ever had this ailment in the past?

1) yes no If yes, when? _____

2) yes no If yes, when? _____

How long has he/she had this ailment? _____

Name _____

SOCIAL HISTORY:

Parents: Married ____ Separated ____ Divorced ____ Life Partner
Parent 1 occupation _____ full time ____ part time ____
Parent 2 occupation _____ full time ____ part time ____
Other Guardian _____ Relationship _____
Others residing in home _____ Relationship _____
Daycare / Preschool / School _____ Where _____
How many hours each day? _____ Days of the week? _____

Family History: Please note if they are alive or dead, age, cause of death, and major medical problems (ex: diabetes, epilepsy, high blood pressure, heart problems, cancer, anemia, kidney problems, alcoholism, depression, birth defects, hepatitis, tuberculosis, breathing problems, etc.)

NAME	AGE	HEALTH PROBLEMS(past & present)
Siblings		
1.		
2.		
3.		

Parents (biological)

- 1.
- 2.

Parents (other)

- 1.
- 2.

Grandparents (biological)

mother's mother - _____
mother's father - _____
father's mother - _____
father's father - _____

Interaction with relatives Who? _____ How Often? _____

Prenatal and Birth History (for children under age 10):

At what week of pregnancy was this child born? _____

Weight gain during pregnancy - _____lb.

Complications during pregnancy (pre-eclampsia, diabetes, spotting, etc.)

of live births _____ # of pregnancies _____

List all medications, social drugs, and alcohol taken during this pregnancy -

Was there an Rh difference between the baby and the mother? _____

Type of Delivery (vaginal, forceps, C-section) - _____

Where was the baby born? (home, hospital, elsewhere) _____

Complications during delivery (excessive bleeding, cord around baby's neck, etc.)

Child's birth weight - _____lb. _____oz.

Complications with the baby (jaundice, breathing problems, etc.) _____

Feeding: Breast fed ____ How long? ____ Cow's milk? ____

Formula fed ____ How long? ____ Type of formula _____

Age solid foods begun ____ What foods? _____

Food allergy / intolerance _____

Favorite foods _____

Name _____

MEDICATIONS:

	now	past	frequency
Ibuprofen	___	___	_____
Tylenol	___	___	_____
Antibiotics	___	___	_____
Asthma Meds	___	___	_____
Fluoride	___	___	_____
Other	_____		

SUPPLEMENTS:

	now	past	dosage/remedy
vitamins	___	___	_____
minerals	___	___	_____
herbs	___	___	_____
homeopathy	___	___	_____

Allergies to drugs or medications: _____

CHILD'S HEALTH HISTORY: (please check)

	Now	Past	Never		Now	Past	Never
Acne	___	___	___	Hyperactivity	___	___	___
Allergies	___	___	___	Insomnia	___	___	___
Anemia	___	___	___	Jaundice	___	___	___
Asthma	___	___	___	Learning Disorder	___	___	___
Bed Wetting	___	___	___	Measles	___	___	___
Birth Defects	___	___	___	Mononucleosis	___	___	___
Bronchitis	___	___	___	Moodiness	___	___	___
Chicken Pox	___	___	___	Mumps	___	___	___
Colic	___	___	___	Pain w/Urination	___	___	___
Constipation	___	___	___	Parasites	___	___	___
Cough/Wheeze	___	___	___	Pertussis	___	___	___
Cradle Cap	___	___	___	Pin Worms	___	___	___
Depression	___	___	___	Pneumonia	___	___	___
Diaper Rash	___	___	___	Psoriasis	___	___	___
Diarrhea	___	___	___	Rubella	___	___	___
Diphtheria	___	___	___	Scarlet Fever	___	___	___
Dizzy Spells	___	___	___	Strep Throat	___	___	___
Earaches/Infections	___	___	___	Stuffy Nose	___	___	___
Eczema	___	___	___	Tonsilitis	___	___	___
Epilepsy/Seizures	___	___	___	Thrush	___	___	___
Fatigue	___	___	___	Undescended testicles	___	___	___
Frequent Infections/Colds	___	___	___	Vomiting spells	___	___	___
Headaches	___	___	___	Other _____			
Heart Murmur	___	___	___	_____			
High Fever	___	___	___	_____			

List any hospitalizations (date and reason) - _____

IMMUNIZATIONS

Please check any of the following tests and immunizations you have had. Also list the year when the last one was done.

Test	Year	Test	Year
Physical Exam	_____	Tetanus Shot	_____
Chest X-Ray	_____	Diphtheria	_____
EKG/ECG	_____	Polio	_____
Blood Transfusion	_____	Measles	_____
Biopsy: Where? When?	_____	Hepatitis B	_____
		Flu	_____
CT Scan/MRI	_____	Other immunizations	_____
German Measles	_____		
HIB	_____	TB Test	_____