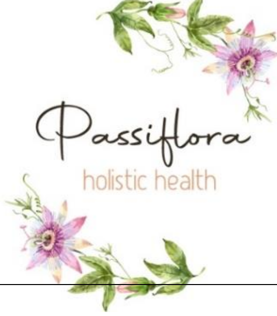

NATUROPATHIC INTAKE FORM
PEDIATRIC PATIENTS

Date:_____/_____/__________

PATIENT INFORMATION

Child's Name:

Date of Birth (mm/dd/yyyy): / / Gender:

Address:

City: Zip:

Birthplace: Home Hospital Is the child yours by: Birth Adopted Other

Mother's Name:

Father's Name:

Child lives with: Both Parents Mom Dad Other:

Home Phone: Work Phone:

Current Physician: Prior Physician

Sibling's names and ages:

Please provide a copy of your child's immunization records

CURRENT MEDICAL CONCERNS

What is the main purpose of this appointment?

Is your child currently being treated for any other medical condition or illness? Y N

Is your child currently taking any medications? List current medications and dose:

Allergies (to medicine/vaccines, list and describe reaction):

Known Food Allergies:

Environmental Allergies:

Special Diet or Food Restrictions:

CHILD'S PAST MEDICAL HISTORY

Child's birth weight (lbs)_______________Length at birth_________Delivered by: Vaginal birth C-Section

Please list any pregnancy complications: ____

Maternal Information During Pregnancy

Was your child premature? _____________

Caffeine use: Type_____________Amount/ Day_________ Alcohol use: Type_____________Amount/ Day ________

Tobacco use: Type_____________Amount/ Day _________

Medication use: Non Prescription Type/ strength____________________Amount/ Day ________

Prescription Type/ strength________________________Amount/ Day ________

During this pregnancy did you have: (Circle all that apply)

Prenatal Care High Blood Pressure Gestational Diabetes Venereal Disease

German (3 day) Measles Any Illness, Infection or High Fever (If yes, describe____________________________)

Infant Health History (Birth to 3 Months)

Age when discharged from Hospital___________Was your baby Jaundiced? No Yes, age_____how long _______

Breastfed ☐ No ☐ Yes,_________months Formula Fed ☐ No ☐ Yes,_________months Formula Name ___________

Has your child had any unusual feeding/ dietary problems? Explain: ____

Developmental History

At what age did your child: Lift head___________Roll over____________Sit alone___________Stand up _____________

Walk alone___________Drink from cup____________Say words____________Toilet Train _____________

Review of Systems

Has your child ever had: (Circle all that apply)

Constitutional: Fever, Chills, Fatigue, Recent weight changes, Headaches, Excess thirst, Hot or Cold intolerances

Diseases: Measles (10 day), Rubella (3-day measles), Mumps, Chicken Pox, Whooping Cough, Rheumatic Fever, Hepatitis (Liver Disorders) Bronchitis or Chronic Cough, Asthma, Pneumonia, Anemia/Blood Disorders

Eyes: Crosses or Wandering eyes, Vision problems, Eye irritation, Frequent headaches, Eye drainage, Squinting, Wears glasses/contact lenses

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Ears/Nose/Mouth/Throat: Frequent ear infections, hearing problems, Ear pain, Runny nose, frequent nose bleeds, frequent stuffed up nose, snoring, mouth breathing, difficulty talking, stuttering, frequent colds or sore throats, persistent hoarseness, dental problems Date of last dental visit ____________________

Cardiovascular: Shortness of breath, chest pain, palpitations

Gastrointestinal: Loss of appetite, Change in bowel movements, nausea, vomiting, diarrhea, constipation, worms, blood in stool, abdominal pain

Genitourinary: Urination problems, painful/ burning urination, blood in urine, unusual urine order, persistent diaper rash, bedwetting problems, discharge from vagina or penis, (Females) 1st period age _____________________

Integumentary (skin): Rash or itching problems, change in hair or nails, slow healing bruises, abnormal moles, cuts easy, bruises after bleeding

Musculoskeletal: Painful or swollen joints, sprains/dislocations/broken bones, muscle coordination/strength problems, posture problems

Neurological: Dizzy or fainting spells, periods of confusion or disorientation, convulsions/ seizures, tremors/shakes, difficulty walking/balancing/handling objects, head injuries, developmental milestone delays

Psychiatric: Frequent nightmares, unusually nervous or high strung, irritable/ temper problems, extreme mood swings, unusually disobedient, problems at school or with friends, suicidal attempt(s)

Family History

Please indicate whether any family members have, or have had the following:

CONDITION	Mother	Father	Sibling	Grandparent(s)
Asthma				
Anemia				
Blood Disorder				
Cancer				
Heart Problems				
High Blood Pressure				
Stroke				
Diabetes				
Thyroid Disease				
Kidney Disease				
Seizure				
Migraines				
Depression / Anxiety				
Alcoholism / Drugs				
ADD / ADHD				
Birth Defects				
Allergies				

Please explain any positive answers above:____

____

____

____

____

Signature of Parent or Guardian : ____

Thank you very much for taking the time to complete this form.