

Pediatric Intake Form

Child's Name: Date:

Date of birth: (M/D/Y) Sex: M F Trans.

Who is filling out the form? (Name and relation):

E-mail Address: Address:

Home #:

Work #:

Cell #:

Please check the number you prefer to be contacted by

With whom does the child live? (Name and Relation):

If not listed above, please write their contact information below.

How did you hear about our Clinic? Please check one of the following:

- | | |
|--|---|
| <input type="checkbox"/> Our Website
<input type="checkbox"/> Patient from our clinic
Name: _____
<input type="checkbox"/> Family or Friend
Name: _____
<input type="checkbox"/> Information Session
<input type="checkbox"/> Web search engine (Eg. Google) | <input type="checkbox"/> National Nutrition Referral or Meeting
<input type="checkbox"/> Healthcare Practitioner
Name: _____
<input type="checkbox"/> Advertisement
Please Describe: _____

<input type="checkbox"/> Other: _____ |
|--|---|

Other health care providers the child is seeing:

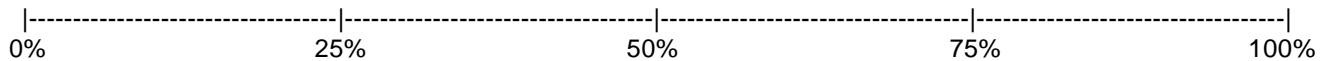
- | | | |
|--|--|--|
| 1. <input style="width: 100%; height: 40px;" type="text"/> | 2. <input style="width: 100%; height: 40px;" type="text"/> | 3. <input style="width: 100%; height: 40px;" type="text"/> |
|--|--|--|

Please list the child's health concerns in order of importance, along with a brief description

1		
2		
3		
4		
5		

What are your goals for the health of your child using naturopathic medicine?

How much of the work are you willing to do to achieve these goals? (Please mark yourself on the line)



Are there certain things that you are not willing or not able to change in your child's life? If so, what?

Medical History

How would you describe your child's general state of health (please check) ? Excellent Good Fair Poor

Please note any illnesses, surgeries or injuries and any hospitalizations, with approximate dates.

Does your child have any known allergies (medicines, environmental, food, etc.)?

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

Has your child had any recurrent infections? If so, please explain. Y N

Please list past prescription medications.

How many times has your child been treated with antibiotics?

Please list what immunizations your child has had and approximately when:

--	--	--

Were there any adverse reactions to vaccination? If so, please list.

What screening tests has your child had (blood, hearing, vision, etc.)?

Family History

Indicate if a close relative of the child (grandparent / parent / sibling) has had any of the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> Epilepsy, Seizures | <input type="checkbox"/> Anemia | <input type="checkbox"/> Juvenile Arthritis |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Kidney Disease | |

Do either of the parents have a chronic illness? If so, please describe:

Environment

Is the child in: School Daycare Homecare Other:

What are your child's favorite activities?

Does the child exercise regularly?

If yes, what does your child do for exercise, how much, how often?

How much television does your child watch?

How often does your child read or get read to?

Does anyone in the child's household smoke?

Are there animals in the home?

Do you know of any toxins or hazards your child may be exposed to (home, hobbies, etc.)? Please describe.

Who also lives in the child's home? Please list name and relation if applicable.

How would you describe the emotional climate of the child's home?

What do you think or feel is contributing to your child's concerns?

Please write anything that you feel is important that has not been covered: