NATUROPATHIC PEDIATRIC INTAKE FORMS

Patients Name:_____ Age:_____ Sex:____
Birthdate:_____/_____/_____
Mother's Name:_____ Father's Name:_____
Home Address:_____Postal Code _____
Home Phone:_____ Work phone:_____
How did you hear about this clinic?_____

1) Primary reason for coming to the clinic?_____
_____
2) When did it first occur?_____
3) What makes it better?_____
4) What makes it worse?_____
5) Have you consulted any other health care practitioners regarding this condition?
Please explain their diagnosis, therapy and results.
_____
_____
_____
6) Please list any other health concerns you have at this time._____
_____
_____
_____

FAMILY HEALTH HISTORY

7) Please indicate whether there is any history of the following conditions in your family and give details below:
Heart disease, Hypertension, Cancer, Diabetes, Arthritis, Allergies, Birth defects, Tuberculosis, Mental illness, Multiple Sclerosis, Auto-immune disorders, Asthma, Psoriasis, Eczema or any other conditions. _____
_____
_____
_____
_____
8) Please indicate if any siblings have a similar condition or any listed above. _____
_____
_____

CHILD'S HEALTH HISTORY

9) Mother's age at child's birth: _____ Father's age:_____
10) Number of previous pregnancies by natural mother, miscarriages, or complications.
_____
_____

11) Please indicate whether any of the following conditions were present during the pregnancy. Bleeding, Nausea, Illness, Hypertension, Diabetes, Physical or emotional trauma, Smoking, Alcohol consumption, drug consumption, Medication.

12) Was the birth process natural? Without medical intervention, such as forceps, C-section, Epidural Anesthesia, etc. If no, please explain:_____

_____

_____

_____

13) Term: Full_____ Premature: _____ Late: _____ weight at birth:_____

14) Was the child breast fed within the first 10 hours after birth?_____

15) Was the child breast fed at all? How long?_____

16) If formulas was given to the child, which kind (milk/soya)_____

17) Age at which solid foods where first introduced._____

18) Did your child require any medical attention, hospitalization, or medication as an infant (before age 2) (Y/N)_____ Please list all surgeries, their approximate dates, why they were performed and if you feel they were successful. _____

_____

_____

20) Please circle the conditions that your child has been vaccinated for: Measles, Mumps, Polio, DPT, MMR, Tetnus, Diptheria, Influenza, other_____

_____

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_____

21) Has your child had the following problems? Jaundice, Colic, Blue baby, Diarrhea, Constipation, Fever, Seizures, Birth defects, Cerebal palsy, Birth injuries, Rashes, Pneumonia, Frequent colds, Tonsillitis, Ear infection other_____

_____

_____

_____

22) List any medication your child has been on (aspirin, Tylenol, decongestants, antibiotics, anti-histamines). _____

_____

_____

23) List any known allergies your child may have: (enviromental, food, medications, etc.). _____

_____

24) Please note any other information which has not already been mentioned that you feel may be pertinent to the treatment of your child._____

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