

# PEDIATRIC INTAKE

This is a detailed pediatric intake form; it includes questions that may seem irrelevant. As naturopathic doctors we need a picture of the whole person to prescribe individually. Please complete it as thoroughly as possible. There are spaces throughout for additional comments if needed. Thank you.

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_

SEX: M / F

DATE OF BIRTH (MM/DD/YYYY): \_\_\_ / \_\_\_ / \_\_\_\_\_ AGE: \_\_\_\_\_

NAME OF PRIMARY GUARDIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

NAME OF PARENTS (if different from Guardian) \_\_\_\_\_ PHONE: \_\_\_\_\_

WHO IS FILLING OUT THE FORM (name & relation) \_\_\_\_\_

EMERGENCY CONTACT (name & relation) \_\_\_\_\_ PHONE: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

OTHER HEALTH CARE PROVIDERS: \_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR CLINIC? \_\_\_\_\_

PLEASE RATE THE GENERAL STATE OF THE CHILD'S HEALTH (1 = poor, 5 = excellent) 1 2 3 4 5

PLEASE LIST / DESCRIBE THE CHILD'S CHIEF CONCERNS (in order or priority):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

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## MEDICAL HISTORY:

PLEASE LIST AND DESCRIBE ANY PAST MEDICAL CONCERNS (eg: illnesses, injuries, hospitalizations, surgeries, traumas)

\_\_\_\_\_  
\_\_\_\_\_

HAS THE CHILD HAD ANY OF THE FOLLOWING? Please check all that apply, rate severity (1 = mild, 3 = severe)

- |   |  |
|---|--|
| <input type="checkbox"/> ASTHMA 1 2 3         | <input type="checkbox"/> MUMPS 1 2 3             |
| <input type="checkbox"/> CHICKEN POX 1 2 3    | <input type="checkbox"/> ROSEOLA 1 2 3           |
| <input type="checkbox"/> EAR INFECTIONS 1 2 3 | <input type="checkbox"/> RUBELLA 1 2 3           |
| <input type="checkbox"/> HEADACHES 1 2 3      | <input type="checkbox"/> SCARLET FEVER 1 2 3     |
| <input type="checkbox"/> IMPETIGO 1 2 3       | <input type="checkbox"/> STREPT INFECTIONS 1 2 3 |
| <input type="checkbox"/> MEASLES 1 2 3        | <input type="checkbox"/> WHOOPING COUGH 1 2 3    |
| <input type="checkbox"/> MONONUCLEOSIS 1 2 3  | COMMENTS: _____                                  |

DOES THE CHILD STILL HAVE THEIR TONSILS? Y / N \_\_\_\_\_

DOES THE CHILD HAVE ANY ALLERGIES (MEDICATIONS, SEASONAL, ENVIRONMENTAL, FOOD)?

\_\_\_\_\_  
\_\_\_\_\_

HOW MANY TIMES HAS THE CHILD BEEN TREATED WITH ANTIBIOTICS? \_\_\_\_\_

PLEASE LIST ANY CURRENT (OR PAST) MEDICATIONS OR SUPPLEMENTS THE CHILD IS (WAS) TAKING:

_____	_____	_____
_____	_____	_____
_____	_____	_____

**VACCINATION HISTORY:**

PLEASE CHECK THE FOLLOWING THAT APPLY (comment on any adverse reactions, if any)

- |   |   |
|---|---|
| <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus) _____ | <input type="checkbox"/> POLIO _____          |
| <input type="checkbox"/> TETANUS BOOSTER _____                      | <input type="checkbox"/> CHICKEN POX _____    |
| <input type="checkbox"/> MMR (measles, mumps, rubella) _____        | <input type="checkbox"/> HEPATITIS A _____    |
| <input type="checkbox"/> HEMOPHILUS INFLUENZA B _____               | <input type="checkbox"/> HEPATITIS B _____    |
| <input type="checkbox"/> FLU _____                                  | <input type="checkbox"/> HPV (Gardasil) _____ |

**FAMILY HISTORY:**

PLEASE CHECK ANY THAT APPLY:

ILLNESS	MOTHER	FATHER	SISTER	BROTHER	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER
ASTHMA								
ALLERGIES								
HEART DISEASE								
STROKE								
BLOOD PRESSURE								
DIABETES								
KIDNEY DISEASE								
ARTHRITIS								
CANCER								
DEPRESSION/ ANXIETY								
MENTAL ILLNESS								
DRUG/ALCOHOL ABUSE								
OTHER								

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**PRENATAL / DELIVERY / LABOR / (NEO) NATAL HISTORY:**

DO NOT KNOW PRENATAL HISTORY

WAS THE PREGNANCY PLANNED? Y / N COMMENTS: \_\_\_\_\_

PLEASE RATE THE HEALTH OF THE FATHER AT CONCEPTION (1 = poor, 5 = excellent) 1 2 3 4 5

PLEASE RATE THE HEALTH OF THE MOTHER AT CONCEPTION (1 = poor, 5 = excellent) 1 2 3 4 5

WHAT WAS THE MOTHER'S AGE AT CONCEPTION? \_\_\_\_\_

WERE THERE ANY PREVIOUS MISCARRIAGES/ABORTIONS? Y / N

PLEASE RATE THE MOTHERS OVERALL HEALTH DURING PREGNANCY (1 = poor, 5 = excellent) 1 2 3 4 5

PLEASE CHECK AND COMMENT ON ALL THAT APPLY TO THE MOTHER'S LIFESTYLE DURING PREGNANCY

- |   |   |
|---|---|
| <input type="checkbox"/> MEDICATIONS _____        | <input type="checkbox"/> EXERCISING _____       |
| <input type="checkbox"/> SUPPLEMENTS _____        | <input type="checkbox"/> PRENATAL CLASSES _____ |
| <input type="checkbox"/> SMOKING _____            | <input type="checkbox"/> DEPRESSION _____       |
| <input type="checkbox"/> ALCOHOL _____            | <input type="checkbox"/> EATING WELL _____      |
| <input type="checkbox"/> RECREATIONAL DRUGS _____ | <input type="checkbox"/> OTHER _____            |

WHERE DID THE LABOUR / DELIVERY TAKE PLACE? \_\_\_\_\_

PLEASE RATE THE OVERALL EXPERIENCE OF THE LABOUR (1 = poor, 5 = excellent): 1 2 3 4 5

PLEASE CHECK AND COMMENT ON ALL THAT APPLY TO THE LABOR AND DELIVERY:

- |  |   |
|--|---|
| <input type="checkbox"/> VAGINAL BIRTH _____ | <input type="checkbox"/> SUCTION _____                  |
| <input type="checkbox"/> C-SECTION _____     | <input type="checkbox"/> EPISIOTOMY _____               |
| <input type="checkbox"/> MEDICATIONS _____   | <input type="checkbox"/> STITCHES _____                 |
| <input type="checkbox"/> ANESTHESIA _____    | <input type="checkbox"/> VITAMIN K ADMINISTRATION _____ |
| <input type="checkbox"/> INDUCTION _____     | <input type="checkbox"/> OTHER CONCERNS _____           |
| <input type="checkbox"/> FORCEPS _____       |   |

PLEASE CHECK AND COMMENT ON ALL THAT APPLY TO THE NEONATAL AND INFANCY PERIODS:

- |   |   |
|---|---|
| <input type="checkbox"/> COLIC _____    | <input type="checkbox"/> RASHES _____             |
| <input type="checkbox"/> JAUNDICE _____ | <input type="checkbox"/> INJURIES _____           |
| <input type="checkbox"/> SEIZURES _____ | <input type="checkbox"/> CONGENITAL DEFECTS _____ |

HOW WAS THE INFANT FED?

- BREAST FED. HOW LONG? \_\_\_\_\_  FORMULA: TYPE \_\_\_\_\_  OTHER (please specify) \_\_\_\_\_

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**DIET / LIFESTYLE:**

DOES THE CHILD FOLLOW SPECIAL DIET? Y N ANY CHANGES IN APPETITE? Y N

HOW MANY GLASSES OF WATER PER DAY? \_\_\_\_\_ POP? \_\_\_\_\_ JUICE? \_\_\_\_\_ MILK? \_\_\_\_\_

DOES THE CHILD EXERCISE? Y / N WHAT TYPE? \_\_\_\_\_ HOW OFTEN? \_\_\_\_\_

HOW MANY HOURS OF TV / VIDEO DOES THE CHILD WATCH? \_\_\_\_\_ COMPUTER? \_\_\_\_\_

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**DEVELOPMENTAL HISTORY:**

AGE CHILD WALKED? \_\_\_\_ TALKED? \_\_\_\_ FIRST WORD? \_\_\_\_\_ TOILET TRAINING: \_\_\_\_\_

ANY ACADEMIC CONCERNS (special education programs or repeating grades)? Y N

ANY DEVELOPMENTAL CONCERNS? Y N

DESCRIBE THE CHILD'S GENERAL MOOD: \_\_\_\_\_

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**ENVIRONMENT:**

LIST THE PEOPLE WITH WHOM THE CHILD LIVES (please specify the relationship with the child):

\_\_\_\_\_

\_\_\_\_\_

ARE THERE ANY SMOKERS IN THE HOUSE? Y / N ARE THERE ANY PETS? Y / N

DOES ANYONE USE DRUGS OR DRINK ALCOHOL IN THE HOUSE? \_\_\_\_\_

HOW IS THE HOUSE HEATED? \_\_\_\_\_

WHAT IS THE EMOTIONAL CLIMATE IN THE HOME? \_\_\_\_\_

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**MISCELLANEOUS:**

IS THERE ANYTHING ELSE YOU THINK IS IMPORTANT ABOUT THE CHILD? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_