New Pediatric Patient Intake

Welcome! Holistic health care and preventive medicine are most effective when the doctor has a complete understanding of your child's health history. Please fill out this questionnaire as thoroughly as possible. Print all information clearly and mark anything you don't understand with a question mark. All information contained in these pages is completely confidential. Email addresses will only be used for contact regarding to your child's health care, if necessary.

Personal Information

Name _____ Preferred Name _____

Age _____ Date of Birth _____/____/_____ ☐ Female ☐ Male Social Security Number _____-_____-_____

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home phone number _____ Is it OK to leave messages? ☐ Yes ☐ No

With whom does this child live? ☐ Mother ☐ Father ☐ Both ☐ Other _____

Emergency contact

Name _____ Relationship _____

Phone (Day) _____ (Evening) _____ (Cell) _____

Address _____

Email address _____

Preferred contact ☐ Day phone ☐ Evening phone ☐ Cell phone ☐ Email

Besides the Emergency Contact, who else has permission to bring your child to see the doctor?

Name	Phone #	Relationship to child

Who may we thank for your referral?

_____

Current Health Conditions

Conditions, symptoms, concerns - in order of priority	Date of onset
(1)	
(2)	
(3)	

Medical History

Primary Care Physician:

Name _____ Clinic _____

Phone _____ Address _____

Have you consulted your PCP about the aforementioned condition(s)? ☐ No ☐ Yes

☐ My child does not have a PCP

Other practitioner(s) you have consulted about the aforementioned condition(s):

Name _____ Specialty _____ Clinic _____

Phone _____ Address _____

Diagnosis / treatment / results _____

_____

☐ Other practitioners listed on reverse

Have you been to a Naturopathic Doctor before? ☐ No ☐ Yes

Name _____ City _____

Phone _____ Dates of treatment _____

Diagnosis / treatment / results _____

_____

Where was your child born? ☐ Hospital ☐ Home ☐ Birth Center ☐ Other _____

Was your child breastfed? ☐ No ☐ Yes - How long? _____

Please indicate if your child has had the following conditions or symptoms by marking "C" for current, "P" for past, or "N" for never:

C	P	N		C	P	N	
☐	☐	☐	Anemia	☐	☐	☐	Gastrointestinal disorder
☐	☐	☐	Asthma	☐	☐	☐	Hay fever
☐	☐	☐	Autoimmune disease	☐	☐	☐	Headaches
☐	☐	☐	Cancer of _____	☐	☐	☐	Head injury
☐	☐	☐	Chicken pox	☐	☐	☐	Hypoglycemia
☐	☐	☐	Circulatory problems	☐	☐	☐	Irritable Bowel Syndrome
☐	☐	☐	Constipation	☐	☐	☐	Mononucleosis
☐	☐	☐	Colic	☐	☐	☐	Nausea
☐	☐	☐	Dental problems	☐	☐	☐	Neurological disease
☐	☐	☐	Diabetes	☐	☐	☐	Seizures
☐	☐	☐	Diarrhea	☐	☐	☐	Sinus problems
☐	☐	☐	Difficulty sleeping	☐	☐	☐	Skin problems
☐	☐	☐	Ear infections	☐	☐	☐	Strep throat
☐	☐	☐	Frequent antibiotic use	☐	☐	☐	Urinary tract infection
☐	☐	☐	Frequent colds or flu	☐	☐	☐	Other _____

Has you child been immunized? ☐ No ☐ Yes - Please check boxes and list age at vaccination below

☐ DTaP _____
☐ HIB _____
☐ Hep A _____
☐ Hep B _____
☐ HPV _____
☐ IPV (polio) _____
☐ Influenza _____
☐ MMR _____
☐ Meningococcal _____
☐ Pc (Pnuemonococcal) _____
☐ Rotavirus _____
☐ Varicella _____

Please list any known allergies:

Drug _____
Environmental _____
Food _____
Other _____

Lifestyle History

Height _____ Weight _____ BMI, if known _____

If your child has daily bowel movements, how many per day? _____
If your child does NOT have daily bowel movements, how many per week? _____
How would you describe them? Color _____
Check all that apply: ☐ Easy ☐ Difficult ☐ Painful ☐ Soft ☐ Dry and hard
☐ Loose ☐ Explosive ☐ Blood ☐ Mucus ☐ Undigested food ☐ Floats ☐ Sinks

What does your child regularly eat and drink? Note the typical time of day and describe all that apply:

Breakfast _____
Mid-morning snack _____
Lunch _____
Mid-afternoon snack _____
Dinner _____
Late-night snack _____

Current dietary restrictions _____
Why? _____
Past dietary restrictions _____
When? Why? _____

Where does your child eat? Check all that apply:
☐ Table ☐ Desk ☐ Bed ☐ In front of the TV ☐ Car ☐ Standing ☐ Walking
☐ Other _____

Sleep _____ hours per night
Are there any problems with sleep? ☐ No ☐ Yes _____

Describe your child's physical activity _____

_____

NAME _____ AGE _____ Page 4

Is your child exposed to second hand smoke on a regular basis? ☐ No ☐ Yes

Mercury amalgam fillings ☐ Never ☐ Past ☐ Present

Does your child live in a new home or a newly remodeled home? ☐ No ☐ Yes

Do you have pets? ☐ No ☐ Yes _____

Does your child watch television? ☐ No ☐ Yes _____ hours per day

Major life change in last year? ☐ No ☐ Yes _____

What therapies have you tried? Please check "C" for therapies you currently use and "P" for those you have used in the past:

C	P		C	P	
☐	☐	Acupuncture	☐	☐	Homeopathy
☐	☐	Chiropractic	☐	☐	Hydrotherapy
☐	☐	Counseling	☐	☐	Physical Therapy
☐	☐	Detoxification	☐	☐	Supplements
☐	☐	Fasting	☐	☐	Other _____

Medications and Supplements

Please list all prescription medications, over-the-counter medicines, natural medicines, vitamins, and supplements your child is currently taking. Use a separate page if necessary.

Name	Dosage	Dates Taken	Reason for taking