

Natural Choices Health Clinic

Your natural choice for health care

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PEDIATRIC INTAKE FORM

Name: _____ Date: _____

Age: _____ Date of Birth: ____/____/____ Female: _____ Male: _____

Mother's name: _____ Father's name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone # (home): (____) _____ Parent's # (cell): (____) _____

Phone # (work): (____) _____ Parent's e-mail address: _____

How did you hear about our clinic? _____

HEALTH HISTORY QUESTIONNAIRE

What are your child's most important health problems? List as many as you can in order of importance:

1. _____

2. _____

3. _____

Does your child have a contagious disease at this time? Y N

If yes, what? _____

Previous Illnesses

Rheumatic fever	Y N	German measles	Y N
Chicken pox	Y N	Measles	Y N
Tonsillitis	Y N	approx. number	_____
Ear infections	Y N	approx. number	_____
Other	Y N	list	_____

PLEASE FILL OUT BOTH SIDES OF EACH PAGE

Has your child had any of the following tests? When Where
Electroencephalogram (EEG)

.....
Psychological evaluation

.....
Hearing tests

.....
Speech/Language tests

Hospitalizations/ Surgeries/ Injuries

What hospitalizations, surgeries or injuries has your child had?

Immunizations

Polio	Y N	Pertussis	Y N
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Tetanus shot	Y N	Diphtheria	Y N
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Measles/Mumps/Rubella	Y N	Influenza	Y N
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Any adverse reactions?	Y N	If yes, what ? _____	
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Allergies

Is your child hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental? _____

Breast fed? _____ how long? _____ Formula? _____ milk / soy _____

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Please list **any** prescription medications, over the counter medications, vitamins or other supplements your child is taking:

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

REVIEW OF SYSTEMS

Y = a condition now P = significant problem in the past N = never had

MENTAL/ EMOTIONAL

Mood Swings	Y	P	N	Anxiety/nervousness	Y	P	N
Irritability	Y	P	N	Cries easily	Y	P	N
Hyperactivity	Y	P	N	Unusual fears	Y	P	N
Introvert/extrovert	Y	P	N	Sleep problems	Y	P	N
Motion/car sickness	Y	P	N	Nightmares	Y	P	N

ENDOCRINE

Heat/cold intolerance	Y	P	N	Fatigue	Y	P	N
Excessive thirst	Y	P	N	Excessive hunger	Y	P	N
Low blood sugar	Y	P	N	High blood sugar	Y	P	N

SKIN

Rashes	Y	P	N	Eczema, Hives	Y	P	N
Acne, Boils	Y	P	N	Itching	Y	P	N

HEAD

Headaches	Y	P	N	Head Injury	Y	P	N
Dizzy spells	Y	P	N	High fevers	Y	P	N

EYES

Glasses or contacts	Y	P	N	Tearing or dryness	Y	P	N
Eye pain/strain	Y	P	N				

EARS

Earaches	Y	P	N	Impaired hearing	Y	P	N
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NOSE AND SINUSES

Frequent colds	Y	P	N	Nose Bleeds	Y	P	N
Stuffiness	Y	P	N	Hay fever	Y	P	N
Sinus problems	Y	P	N	Loss of smell	Y	P	N

MOUTH AND THROAT

Frequent sore throat	Y	P	N	Canker sores	Y	P	N
Breath odor	Y	P	N				

RESPIRATORY

Cough	Y	P	N	Wheezing	Y	P	N
Asthma	Y	P	N	Bronchitis	Y	P	N

CARDIOVASCULAR

Heart disease Y P N Murmurs Y P N

URINARY

Frequent urination Y P N Bed wetting Y P N

GASTROINTESTINAL

Belching/passing gas Y P N Stomachaches Y P N

Constipation Y P N Diarrhea Y P N

Bowel Movements How often? _____

MUSCULOSKELETAL

Joint pain/stiffness Y P N Muscle spasms/cramps Y P N

Broken bones Y P N

BLOOD/PERIPHERAL VASCULAR

Anemia Y P N Easy bleeding/bruising Y P N

Is there any information about your child's health that you would like to add?

What expectations do you have for your child from working with our clinic?

Welcome! We're honored to be of service for you and your child!