

Natural Choices Health Clinic

Your natural choice for health care

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PEDIATRIC INTAKE FORM (Birth - 5 years)

Patient's name: _____ Date of first visit: _____

Age: _____ Date of Birth: ____/____/____ Gender: female _____ male _____

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

Address: _____ City: _____ State: ____ Zip: _____

Phone # (home): (____) _____ Parents # (cell): (____) _____

Phone # (work): (____) _____ Parents e-mail address: _____

How did you hear about this clinic? _____

Name of Dr.'s Office/Hospital/Clinic where your child's health records are kept: _____

Reason for referral or presenting problems: _____

MEDICATIONS	Now	Past		Now	Past
Aspirin	_____	_____	Antibiotics	_____	_____
Tylenol	_____	_____	Anti-histamine	_____	_____
Decongestant	_____	_____	Other	_____	_____
Ibuprofen	_____	_____	Allergies to medicines	_____	

MEDICAL HISTORY

_____ Chicken pox _____ Scarlet fever _____ Tonsillitis, approx. no. _____
_____ Measles _____ Pneumonia _____ Ear infections, no. _____
_____ Mumps _____ Frequent colds _____ other (please list) _____
_____ Rubella _____ Rheumatic fever

Has your child had any of the following tests? When WhereResults
Electroencephalogram
Psychological evaluation
Hearing
Speech/Language

Injuries/Surgeries/Hospitalizations (please list): _____

IMMUNIZATIONS

_____ Measles _____ Polio _____ MMR _____ Smallpox _____ Diphtheria
_____ Mumps _____ DPT _____ Tetanus _____ Influenza
Others (list) _____

Any adverse reactions? Y N What? _____

FAMILY HISTORY

_____ Heart disease _____ Diabetes _____ Birth defects
_____ Hypertension _____ Arthritis _____ Tuberculosis
_____ Cancer _____ Allergies _____ Mental illness

PLEASE COMPLETE BOTH SIDES

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications? _____

Mother's age at child's birth? _____

Mother's health during pregnancy?

- | | |
|--------------------|---|
| _____ Bleeding | _____ Physical or emotional trauma |
| _____ Nausea | _____ Cigarettes, alcohol, drug consumption |
| _____ Illnesses | _____ Medications |
| _____ Hypertension | _____ Thyroid problems |
| | _____ Diabetes |

BIRTH HISTORY

Term: Full _____ Premature _____ Late _____ Weight at birth _____

Length of labor _____ Complications? _____

Did your child have any of the following problems shortly after birth?

- | | | |
|----------------------|----------------------|-----------------|
| _____ Birth defects | _____ Birth injuries | _____ Blue baby |
| _____ Cerebral palsy | _____ Seizures | _____ Jaundice |
| _____ Colic | _____ Fever | _____ Rashes |

Other (explain) _____

Child's sleep patterns (first year) _____

Food intolerances (if any) _____

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

Age began solids _____ Which foods? _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS (mark **Y** if current, **P** significant past symptom)

- | | | |
|----------------------|--------------------------|--------------------------|
| _____ Hives | _____ Burning of urine | _____ Bloody urine |
| _____ Eczema | _____ Frequent urination | _____ Cries easily |
| _____ Bleeding gums | _____ Heart murmur | _____ Nervous |
| _____ Nose bleeds | _____ Vomiting spells | _____ Sleep problems |
| _____ Acne | _____ Anemia | _____ Night sweats |
| _____ High fevers | _____ Stomach aches | _____ Sensitive to light |
| _____ Chronic rash | _____ Jaundice | _____ Body/breath odor |
| _____ Hearing loss | _____ Easy bruising | _____ Motion sickness |
| _____ Diarrhea | _____ Flat feet | _____ No appetite |
| _____ Sore throats | _____ Constipation | _____ Nightmares |
| _____ Headaches | _____ Gas | _____ Canker sores |
| _____ Frequent colds | _____ Bleeding tendency | _____ Unusual fears |
| _____ Wheezing | _____ Joint pains | _____ Excessive fatigue |
| _____ Cough | _____ Dizzy spells | _____ Hair loss |

DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Thank you. We look forward to helping your child in any way we can.