Balanced Family
NATURAL MEDICINE

PEDIATRIC INTAKE FORM (12 and younger)

Patient's Name: _____Date: _____
Age: _____ Date of Birth: _____ Gender: Female / Male
Parent/Guardian's Name: _____Insurance:_____
Address: _____
City: _____ State: _____ Zip: _____
Telephone (home): _____ (Parent's work):_____
Parent's email address: _____
How did you hear about this clinic? _____
Have any other family members already been a patient at this clinic? _____
Name of doctor's office/hospital/clinic where your child's health records are kept:
_____
Reason for referral or presenting problems:
_____
_____

MEDICATIONS

NOW PAST

____ ____ Aspirin

____ ____ Decongestants

____ ____ Tylenol

____ ____ Anti-histamine

NOW PAST

____ ____ Antibiotics

____ ____ Ibuprofen

____ ____ Other:
_____

Please list any allergies to foods or medications:

_____
_____
_____

Please list any medications or supplements your child is currently taking with dosages:

_____ _____
_____ _____
_____ _____

MEDICAL HISTORY

____ Chicken pox

____ Scarlet fever

____ Tonsillitis, approx no. of times: _____

____ Measles

____ Pneumonia

____ Ear infections, approx no. of times: _____

____ Mumps

____ Frequent colds

____ Strep throat, approx no. of times: _____

____ Rubella

____ Rheumatic fever

____ Other: _____

_____

Has your child ever had any of the following? WHEN WHERE RESULTS

Electroencephalogram (EEG):
_____

Psychological evaluations:
_____

Hearing test:
_____

Speech/language tests:
_____

Injuries/surgeries/hospitalizations (please list):
_____
_____

IMMUNIZATIONS (Dates)

_____ MMR

_____ Rotavirus

_____ DTaP

_____ Chicken Pox

_____ Small Pox

_____ Pneomococcal

_____ Hepatitis A

_____ Hepatitis B

_____ H. influenza

_____ Polio

_____Others

Adverse Reactions:
_____
_____

FAMILY HISTORY (Which members)

____ Heart disease
____ Diabetes
____ Birth defects
____ Hypertension
____ Arthritis
____ Tuberculosis
____ Cancer (type?)
____ Allergies
____ Asthma
____ Mental illness
____ Osteoporosis
____ Other significant:
_____
_____
_____

PRENATAL HISTORY

Mother's age at child's birth: _____

Mother's health during pregnancy:
Bleeding _____ Nausea _____ Physical or emotional trauma _____
Illnesses _____
Hypertension _____ Cigarettes, alcohol, drug consumption _____
Medications _____ Diabetes _____ Thyroid problems_____

BIRTH HISTORY

Term: ____Full____ Premature____ Late Length of Labor:_____
Complications:_____ Birth city & state: _____
Birth time: _____ Birth weight:_____

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

____ Rashes
____ Birth injuries
____ Cyanosis (blue color)
____ Jaundice
____ Seizures
____ Cerebral palsy
____ Colic
____ Fever
____ Birth defects
Other_____
_____
_____
_____

Child's sleep patterns (1st year):
_____

Food intolerances:
_____
Breast fed: Y / N How long: _____ Formula: Y / N Type (milk, soy):_____
Age began solids: _____
Initial foods:
_____
Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

CURRENT SYMPTOMS

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

DIET

Please describe your child's typical daily diet:

Breakfast:

_____

Lunch:

_____

Dinner:

_____

Snacks:

_____

Drinks:

_____