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: _____E-mail:_____
How did you hear about 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
Complications:_____
Birth weight:_____
Length of Labor:_____
Birth city & state: _____

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_____

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

CURRENT SYMPTOMS

____ Hives
____ Burning urine
____ Bloody urine
____ Frequent urination
____ Cries easily
____ Bleeding gums
____ Heart murmur
____ Anxious
____ Nose bleeds
____ Vomiting spells
____ Sleep problems
____ Asthma
____ Acne
____ Anemia
____ Night sweats

____ High fevers
____ Jaundice
____ Sensitive to light
____ Chronic rash
____ Stomach aches
____ Diarrhea
____ Hearing loss
____ Easy bruising
____ Sore throats
____ No appetite
____ Body/breath odor
____ Constipation
____ Nightmares
____ Frequent colds
____ Bleeding tendency
____ Unusual fears
____ Wheezing
____ Joint pains
____ Excessive fatigue
____ Cough
____ Dizzy spells
____ Hair loss
____ Eczema
____ Allergies
Other: _____
_____

DIET

Please describe your child's typical daily diet:

Breakfast:
_____

Lunch:
_____

Dinner:
_____

Snacks:
_____

Drinks:
_____