Balanced Family
NATURAL MEDICINE

PEDIATRIC INTAKE FORM (12 and younger)

Patient's Name: _____Date: _____

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

Patient's Address: _____ Patient Phone:_____

Parent/Guardian's #1 Name: _____ Date of Birth:_____

Address (if different from Patient's): _____ Ph: _____

Parent/Guardian's #2 Name: _____ Date of Birth:_____

Address (if different from Patient's): _____ Ph: _____

E-mail: _____

Emergency Contact: _____ Ph: _____

Alternate Emergency Contact: _____ Ph: _____

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

	Mother	Father	Brothers	Sisters	Maternal GM	Maternal GF	Paternal GM	Paternal GF
Age (if living)								
Health (G=good, P=poor)								
Age at death (if deceased)								
Cause of Death								
Check those Applicable								
Cancer								
Diabetes								
Heart Disease								
High Blood Pressure								
Stroke								
Epilepsy								
Mental Illness								
Asthma/Hayfever/Hives								
Allergies								
Eczema/Psoriasis								
Anemia								
Kidney Disease								

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 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_____

_____

_____

_____

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: _____
_____