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PEDIATRIC INTAKE FORM

Name:_____ Date:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone (home):( )_____(work):( )_____(cell):( )_____

Email address:_____

Age:_____ Date of Birth:_____ Gender: Female/Male/Non-binary/_____

Education:_____

Race/Ethnic Origin (circle): African African American Asian Caucasian
Native American Pacific Islander Hispanic Other:_____

Name of parent(s) or guardian(s):_____ Relationship to you:_____

Emergency Contact:_____ Relationship to you:_____

Phone (home):( )_____(work):( )_____ (cell):( )_____

Address:_____

How did you hear about this clinic?_____

Has any other family member already been a patient at this clinic?_____

Have you ever seen a Naturopathic Physician (NMD) before? Yes / No

Would you like to receive health newsletters from the clinic as they become available? Yes / No

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CURRENT PROBLEM LIST

What are your most important health problems? List them in order of importance and time of onset

1._____ 4._____

2._____ 5._____

3._____ 6._____

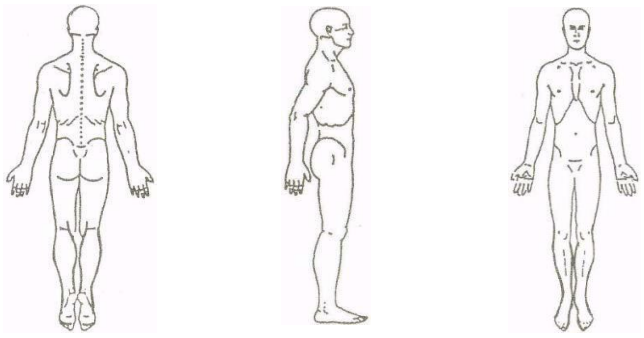
Do you have any known contagious diseases at this time? Yes / No

If yes, what?_____

Please list any current diagnoses:

1._____ 3._____

2._____ 4._____



Please mark your areas of pain

Please indicate your CURRENT pain level on the chart below:

|----------|----------|----------|----------|----------|----------|----------|----------|---------|----------|

0 1 2 3 4 5 6 7 8 9 10

(No pain) (Moderate pain) (Worst Pain)

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GENERAL

Height:_____ Weight:_____ Weight one year ago:_____

Maximum weight:_____ When:_____

Rate your energy during the day (time and level (1-10; 10=best) Best?_____ Worst?_____

Main interest and hobbies:_____

Exercise: Y / N If so, what kind and how often:_____

Watch TV: Y / N If so, how many hours?_____ Read: Y / N If so, how many hours?_____

Do you have a religious or spiritual practice? Y / N If so, what kind?_____

Are you currently receiving health care? Yes / No

If yes, where and from who?_____

If no, are you planning to establish primary care with us? Y / N

When and where did you last receive medical or health care?_____

What was the reason?_____

Do you currently have (circle): Advanced Directives Power of Attorney Will

FAMILY HISTORY

Do you or anyone in your family have a history of any of the following? (Please circle and say who)

Heart disease	High cholesterol	High Blood Pressure
Diabetes	Stroke	Cancer
Kidney disease	Arthritis	Anemia
Asthma	Glaucoma	Mental illness
Eczema	Epilepsy	Hay fever/Hives

Any other relevant family history?_____

What is your family heritage?_____

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CHILDHOOD ILLNESSES

Birth city and state:_____ Birth time:_____ Birth weight:_____

Please circle whether you had any of the following as a child:

Rheumatic fever	Diptheria	Scarlet fever	Chicken pox
German Measles	Measles	Mumps	Ear infections

VACCINE HISTORY (check all that apply)

- ☐ DPT (Diphtheria, Pertussis, Tetanus)
- ☐ Tetanus Booster (Usually DT) When?_____
- ☐ Polio injection/Polio oral
- ☐ MMR (Measles, Mumps, Rubella)
- ☐ HBV (Hepatitis B)
- ☐ Hepatitis A vaccine
- ☐ Other (Flu shot, etc) What and When:_____

HOSPITALIZATIONS/SURGERY/IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs have you had?

_____ Year_____ _____ Year_____

_____ Year_____ _____ Year_____

_____ Year_____ _____ Year_____

ALLERGIES

Are you hypersensitive or allergic to:

Any drugs?_____

Any foods?_____

Any environmental or chemical?_____

ENVIRONMENTAL HISTORY

Do you have amalgam fillings? Y / N If yes how many and for how long?_____

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Do you have past of current history of work related chemical exposure? Y / N

If yes, what chemicals?_____

Zip code of where you lived most of your life:_____

MEDICATION

Please list **all medications** (including over the counter) that you are currently taking and why. Please indicate dose and frequency.

_____Start date_____ _____Start date_____

_____Start date_____ _____Start date_____

_____Start date_____ _____Start date_____

_____Start date_____ _____Start date_____

Have you taken Aspirin, Ibuprofen, Naproxen or any steroids for a long period of time (3 weeks or longer)? Y / N

If yes for how long and for what?_____

VITAMINS AND SUPPLEMENTS

Please list all vitamins and supplements you are taking and why (Please indicate dose and frequency)

_____Start date_____ _____Start date_____

_____Start date_____ _____Start date_____

_____Start date_____ _____Start date_____

_____Start date_____ _____Start date_____

TYPICAL FOOD INTAKE

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

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Water:_____ Coffee:_____ Alcohol:_____

FOR THE FOLLOWING, PLEASE CIRCLE:

Y=Yes, a condition you have now **N**=No, never had **P**=a significant problem in the past

GENERAL

Do you sleep well?	Y	N	P
Average 6-8 hours?	Y	N	P
Wake rested?	Y	N	P
Have a supportive relationship?	Y	N	P
Have a history of abuse?	Y	N	P
Experienced a major trauma?	Y	N	P
Use recreational drugs?	Y	N	P
Treated for drug dependence?	Y	N	P
Use alcoholic beverages?	Y	N	P
Use tobacco?	Y	N	P
If in the past, how many years?_____			
How many packs per day?_____			
Do you enjoy your work?	Y	N	P
Take vacations?	Y	N	P
Spend time outside?	Y	N	P
Eat three meals a day?	Y	N	P
Do you go on diets often?	Y	N	P
Do you eat out often?	Y	N	P
Do you drink coffee?	Y	N	P
Drink black/green tea?	Y	N	P
Drink soda?	Y	N	P
Do you eat refined sugar?	Y	N	P
Do you add salt to your food?	Y	N	P

NEUROLOGIC

Seizures?	Y	N	P
Muscle weakness?	Y	N	P
Loss of memory?	Y	N	P
Vertigo or dizziness?	Y	N	P
Paralysis?	Y	N	P
Numbness or tingling?	Y	N	P
Easily stressed?	Y	N	P
Loss of balance?	Y	N	P

ENDOCRINE CONT.

Heat or cold intolerance?	Y	N	P
Hyperthyroid?	Y	N	P
Diabetes?	Y	N	P
Excessive hunger?	Y	N	P
Seasonal depression?	Y	N	P
Difficulty exercising?	Y	N	P

IMMUNE

Reactions to immunizations?	Y	N	P
Chronically swollen glands?	Y	N	P
Slow wound healing?	Y	N	P
Chronic fatigue syndrome?	Y	N	P
Chronic infections?	Y	N	P
Night sweats?	Y	N	P

EARS

Impaired hearing?	Y	N	P
Ringing in ears?	Y	N	P
Dizziness?	Y	N	P
Ear infections?	Y	N	P

EYES

Impaired vision?	Y	N	P
Cataracts?	Y	N	P
Glaucoma?	Y	N	P
Spots in vision?	Y	N	P
Color blindness?	Y	N	P
Tearing or dryness?	Y	N	P
Eye pain or strain?	Y	N	P

HEAD

Headaches?	Y	N	P
Migraines?	Y	N	P

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ENDOCRINE

Hypothyroid?	Y	N	P
Hypoglycemia?	Y	N	P
Excessive thirst?	Y	N	P
Fatigue?	Y	N	P

NOSE AND SINUS CONT.

Sinus problems?	Y	N	P
Nose bleeds?	Y	N	P
Hay fever?	Y	N	P
Loss of smell?	Y	N	P

NECK

Lumps in neck?	Y	N	P
Goiter?	Y	N	P
Difficulty swallowing?	Y	N	P
Pain or stiffness in neck?	Y	N	P

MOUTH AND THROAT

Frequent sore throat?	Y	N	P
Copious saliva?	Y	N	P
Sore tongue or lips?	Y	N	P
Hoarseness?	Y	N	P
Jaw clicks?	Y	N	P
Teeth grinding?	Y	N	P
Gum problems?	Y	N	P
Dental cavities?	Y	N	P

SKIN

Rashes?	Y	N	P
Acne/boils?	Y	N	P
Change in skin color?	Y	N	P
Lumps or bumps on skin?	Y	N	P
Eczema or hives?	Y	N	P
Itching?	Y	N	P
Perpetual hair loss?	Y	N	P

RESPIRATORY

Cough?	Y	N	P
Sputum?	Y	N	P
Asthma?	Y	N	P
Wheezing?	Y	N	P
Head injury?	Y	N	P
Jaw or TMJ problems?	Y	N	P

NOSE AND SINUS

Frequent colds?	Y	N	P
Stuffiness?	Y	N	P

GASTROINTESTINAL

Trouble swallowing?	Y	N	P
Change in thirst?	Y	N	P
Change in appetite?	Y	N	P
Nausea/vomiting?	Y	N	P
Ulcer?	Y	N	P
Jaundice?	Y	N	P
Gall bladder disease?	Y	N	P
Liver disease?	Y	N	P
Hemorrhoids?	Y	N	P
Pancreatitis?	Y	N	P
Heartburn?	Y	N	P
Abdominal pain or cramps?	Y	N	P
Belching or passing gas?	Y	N	P
Constipation?	Y	N	P

Bowel movements: how often?_____

Is this a change?_____

Black stool?	Y	N	P
Blood in stools?	Y	N	P

MENTAL/EMOTIONAL

Treated for emotional problems?	Y	N	P
Depression?	Y	N	P
Anxiety or nervousness?	Y	N	P
Poor concentrations?	Y	N	P
Do you have mood swings?	Y	N	P
Considered suicide?	Y	N	P
Attempted suicide?	Y	N	P
Tension?	Y	N	P
Memory problems?	Y	N	P

URINARY

Increased frequency of urination?	Y	N	P
Inability to hold urine?	Y	N	P
Pain in urination?	Y	N	P

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Bronchitis?	Y	N	P
Coughing up blood?	Y	N	P
Shortness of breath?	Y	N	P
Shortness of breath—lying down	Y	N	P
Pain in breathing?	Y	N	P
Emphysema?	Y	N	P
Tuberculosis?	Y	N	P

MUSCULOSKELETAL

Joint pain or stiffness?	Y	N	P
Arthritis?	Y	N	P
Broken bones?	Y	N	P
Weakness?	Y	N	P
Muscle spasms or cramps?	Y	N	P
Sciatica?	Y	N	P

BLOOD

Anemia?	Y	N	P
Easy bleeding or bruising?	Y	N	P
Cold hands/feet?	Y	N	P
Deep leg pain?	Y	N	P
Thrombophlebitis?	Y	N	P
Varicose veins?	Y	N	P

FEMALE REPRODUCTIVE

Age of first menses:_____
Age of last menses (if menopausal):_____
Length of cycle:_____days
Duration of menses:_____ days

Are your cycles regular?	Y	N	P
Painful menses?	Y	N	P
Heavy or excessive flow?	Y	N	P
PMS?	Y	N	P

Symptoms:_____
_____

Bleeding between cycles?	Y	N	P
Clotting?	Y	N	P
Endometriosis?	Y	N	P
Ovarian cysts?	Y	N	P
Vaginal odor?	Y	N	P
Vaginal discharge?	Y	N	P

Date of last PAP smear:_____

Abnormal PAP?	Y	N	P
Frequency at night?	Y	N	P
Frequent UTIs?	Y	N	P
Kidney stones?	Y	N	P

FEMALE REPRODUCTIVE CONT.

Genital warts?	Y	N	P
Syphilis?	Y	N	P
Difficulty conceiving?	Y	N	P
Are you pregnant?	Y	N	P

Number of pregnancies:_____
Number of live births:_____
Number of miscarriages:_____
Number of abortions:_____

Do you do self breast exams?	Y	N	P
Breast pain/tenderness?	Y	N	P
Breast lumps?	Y	N	P
Nipple discharge?	Y	N	P
Menopausal symptoms?	Y	N	P

MALE REPRODUCTIVE

Are you sexually active?	Y	N	P

Sexual orientation:_____
Birth control? Type:_____

Discharge or sores?	Y	N	P
Gonorrhea?	Y	N	P
Herpes?	Y	N	P
Chlamydia?	Y	N	P
Genital warts?	Y	N	P
Syphilis?	Y	N	P
Hernias?	Y	N	P
Testicular masses?	Y	N	P
Testicular pain?	Y	N	P
Prostate disease?	Y	N	P
Impotence?	Y	N	P
Premature ejaculation?	Y	N	P

Date of last annual exam:_____

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Cervical dysplasia?	Y	N	P
Are you sexually active?	Y	N	P
Sexual orientation:_____			
Birth control? Type:_____			
Pain during intercourse?	Y	N	P
Gonorrhea?	Y	N	P
Herpes?	Y	N	P
Chlamydia?	Y	N	P