

# Idaho Naturopathic Medicine

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## PEDIATRIC PATIENT INTAKE FORM

Today's Date \_\_\_\_\_

### PERSONAL INFORMATION

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Child lives with \_\_\_\_\_

Mailing Address \_\_\_\_\_ Email: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Address of other parent (if different from above) \_\_\_\_\_

Mother's phone (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Father's phone (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Current school \_\_\_\_\_ Grade \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

### MEDICAL HISTORY

List current health concerns in order of importance:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all prescription medications, nutritional supplements, herbs, or homeopathic remedies currently being taken. Please list doses if known.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any medications, natural or prescription, your child has taken in the past: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Allergy to any medicines, if so what? \_\_\_\_\_

List past surgeries or hospitalizations. Please list age.

Blood type (A/B/O) \_\_\_\_\_

Has your child been immunized? \_\_\_\_\_ If so, has the recommended schedule been followed? \_\_\_\_\_

If not, please explain \_\_\_\_\_

Has there been any negative reaction to vaccinations? \_\_\_\_\_

FAMILY MEDICAL HISTORY

Do any close relatives (grandparents, parents, siblings) have any of the following medical conditions?

<b>Disease</b>	<b>Relative</b>	<b>Disease</b>	<b>Relative</b>
High Blood Pressure	_____	Birth Defects	_____
Heart Attack, Stroke	_____	Suicide	_____
Obesity	_____	Depression	_____
Diabetes	_____	Mental Illness	_____
Glaucoma	_____	Autism	_____
Asthma	_____	Asperger's	_____
Hay Fever	_____	Alcoholism	_____
Eczema	_____	Epilepsy	_____
Skin Disease	_____	Ulcers	_____
Food Allergies	_____	Arthritis	_____
Emphysema	_____	Gout	_____
Tuberculosis	_____	Thyroid Disease	_____
Lung Cancer	_____	Easy Bleeding	_____
Breast Cancer	_____	Sickle Cell Anemia	_____
Other Cancer	_____	Osteoporosis	_____
		Other	_____

Has your child lived in a house built prior to 1973? \_\_\_\_\_

Has your child been exposed to a broken mercury thermometer? \_\_\_\_\_

Has your child lived in a dwelling with mold or water damage? \_\_\_\_\_

Has your child lived, played, or gone to school near:

- Agricultural spraying \_\_\_\_\_
- Pesticide applications \_\_\_\_\_
- Busy roads \_\_\_\_\_

Does your child's behavior change after:

- Eating certain foods \_\_\_\_\_
- Eating sugary foods \_\_\_\_\_
- Eating foods with dyes \_\_\_\_\_

How often does your child have a bowel movement? \_\_\_\_\_

BIRTH HISTORY

Birth order of this child \_\_\_\_\_ Number of siblings \_\_\_\_\_

Where there any complications during pregnancy or labor and delivery? Please explain. \_\_\_\_\_

\_\_\_\_\_

DIET

How was your child fed as an infant? Breast fed? \_\_\_\_\_ How long? \_\_\_\_\_

Formula? \_\_\_\_\_ Type? \_\_\_\_\_

What age did your child begin eating solid foods? \_\_\_\_\_ Which foods? \_\_\_\_\_

Any unusual reactions to solid foods as an infant? \_\_\_\_\_

Please describe your child's typical daily diet. If breastfeeding, describe mother's diet.

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Drinks \_\_\_\_\_

Does your child eat school prepared meals or snacks? \_\_\_\_\_

Which foods, condiments, flavors does your child crave? \_\_\_\_\_

\_\_\_\_\_

Which foods, condiments, flavors does your child dislike? \_\_\_\_\_

Does your child have any food sensitivities or intolerances, either current or in the past? \_\_\_\_\_

\_\_\_\_\_

Is there anything you wish to discuss about behavior or emotions? If so, please explain.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there any thing else you wish to add? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Thank you for taking the time to complete this form.