NaturaMed
NATURAL FAMILY MEDICINE

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Confidential Pediatric Intake Form

*PLEASE **PRINT** CLEARLY AND LEGIBLY TO ASSURE ACCURACY*

Today's Date: _____

Patient name: _____ Age: _____ M or F

Birthdate____/____/____ Grade in School: _____ School Attending: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Physical Address: _____ City: _____ State: ____ Zip: _____

Mother's Name and occupation:_____

Father's Name and occupation:_____

Parents are (circle): Married Separated Divorced Living Together Other_____

Home phone: _____Mom's Cell Phone: _____Dad's Cell phone: _____

Best number for messages:_____ Contact Email:_____

Sibling(s) names and ages: _____
Besides the mother and father, does anyone else take care of the child? No Yes

Who? _____ How often? _____

Primary Care Doctor: _____ Referred by: _____

Has the child seen a dentist? Yes No Dentist's name? _____Last visit? _____

How would you rate this child's health in general? Excellent Good Fair Poor

Reason for Today's Office Visit: _____

Has child been seen by any other doctor(s) or professionals for this complaint? Yes No

Has child had any blood work or other tests done? If yes, please list what:

_____

_____

_____

Present Health Concerns

Please list most important health concerns in order of significance.	Prior diagnosis of this problem? If so, what?
1.	
2.	
3.	
4.	

Please list any operations or hospitalizations, reasons and year occurred:
1. _____
2. _____
3. _____
4. _____
Please list any allergies to medication or life threatening allergies and reaction:_____
_____
_____

Any other allergies – environmental, animal, food? _____
_____

Previous Medical History

Yes *indicates the child gets the problem regularly;* ***No*** *indicates the child never had the problem;* ***P****ast indicates the child had the problem in the past but not recently. Please circle the correct one for your child.*

Ear Infections? Yes No Past
*If has had, how many total?*_____
If yes or past, how were they treated? _____
Colds? Yes No Past
*If has had, how many total?*_____
If yes or past, how were they usually treated? _____
Strep throat? Yes No Past
If has had, how many total?
If yes or past, how was it treated? _____
Eczema, Psoriasis? Yes No Past
If yes or past, how was it treated? _____
Anemia? Yes No Past
Seizures? Yes No Past
Broken bones? Yes No Past
Asthma? Yes No Past
Frequent urination or bed wetting? Yes No Past

How many times has the child taken antibiotics?_____

What other medicine has the child taken? How often?
1. _____
2. _____
3. _____
4. _____

Hearing tests Normal: Yes No Not Tested
Vision Tests Normal: Yes No Not Tested
Any speech impediments: Yes No Past
Learning impediments: Yes No Don't know

Vaccination History: ***Yes****, has had;* ***No****, has not;* ***Some****, did not finish all shots or on alternate schedule*

Hep B	Yes	No	Some	Influenza	Yes	No	Some
RotaVirus	Yes	No	Some	MMR	Yes	No	Some
DPT:	Yes	No	Some	Varicella (chkpox)	Yes	No	Some
Hib:	Yes	No	Some	Hep A	Yes	No	Some
Pneumococcal	Yes	No	Some	Meningococcal	Yes	No	Some
Polio (inactivated)	Yes	No	Some	Other: _____			

Any reactions to vaccinations? If so, please explain:_____

Date of last physical/annual exam: _____

Please check the 'yes' box next to each condition that applies to the child's mother, father or other family members. Please note whether the condition is in the past or currently by denoting 'P' for past, or 'C' for current. Indicate who had/has the condition in the 'relation' column.

	YES	Relation	Date Resolved Past (P) Current (C)		YES	Relation	Date Resolved Past (P) Current (C)
Alcoholism/Drug Addiction				High Blood Pressure			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				Headaches/migraines			
Asthma				Kidney Disease			
Cancer (type?)				Mental Illness			
Depression				Stroke			
Diabetes				Tuberculosis			
Eczema/Psoriasis				Other			

Mother's Pregnancy history

Age at conception:_____Have other children already? Yes No

Prenatal Care during pregnancy? _____

Health During Pregnancy:

Smoking: Yes No

Coffee: Yes No

Recreational drugs: Yes No

Preeclampsia: Yes No

Vaginal birth: Yes No

Diabetes: Yes No

Nausea/Vomiting: Yes No

Emotional Stress: Yes No

Length of Labor:_____

Traumatic birth: Yes No

If the birth was difficult, please explain: _____

_____

_____

_____

Health of baby at birth: _____

_____

APGAR Score: _____

Child breastfed: Yes No

For how long:_____

When put on formula:_____What formula was used:_____

When was child put on solid food:_____

When did child Walk:_____Talk:_____

Develop Teeth:_____

Health History of Child

Jaundice as baby:	Yes	No	Colic:	Yes	No
Cradle cap:	Yes	No	Anemia:	Yes	No
Eczema or psoriasis:	Yes	No	Asthma:	Yes	No
Diarrhea:	Yes	No	Warts:	Yes	No
Constipation:	Yes	No	Nightmares:	Yes	No
Finicky eating:	Yes	No	Bed-wetting:	Yes	No
Poor teeth:	Yes	No	Tantrums:	Yes	No
Chronic sniffles:	Yes	No	Disobedient:	Yes	No
Bad foot odor:	Yes	No	Fears/Phobia:	Yes	No
Very sweaty baby/child:	Yes	No	Diaper Rash:	Yes	No
Hyperactivity:	Yes	No	Early Puberty:	Yes	No
Growing pains:	Yes	No	Stomach aches:	Yes	No

Any particular household stressors child has witnessed or gone through:
1._____
2._____
3._____

Typical Day's Diet and approximate times.
Breakfast:_____
Snack:_____
Lunch:_____
Snack:_____
Supper:_____
Snack:_____

Do you follow any particular dietary regimens or restrictions? If yes, Please describe:
_____
How much water does the child drink? _____ Tap, bottled, filtered, other
How much juice does the child drink? _____ What type? _____
Other fluids (such as GatorAde, Vitamin Water, soda pop etc) _____

Family Health Habits:
How often does your child use a seatbelt or car seat? Never Rarely Sometimes Often Always
How often does your child wear a helmet when participating in sports such as bike riding, skiing, skateboarding, etc? Never Rarely sometimes Often Always
Does your home have smoke detectors? Yes No
Does your home have carbon monoxide detectors? Yes No
Do you have guns in your house? Yes No If yes, are they kept locked up? Yes No
Does anyone in the household smoke? Yes No Explain: _____
Do you feel that you live in a safe place? Yes No Explain: _____

Toxin Exposure:
Has the child ever lived near a refinery or other highly polluted area?_____
Has the child ever lived in a house with lead paint?_____
Has the child ever lived in a house that had new paint, cabinets, carpeting installed, or a new mattress and did that seem to affect their health at all?_____
Do you spray pesticides or herbicides around the house or use other toxic chemicals?_____
_____
Does the child seem particularly sensitive to perfumes or other vapors? Yes No Explain_____
_____
Does the child have any cavities or fillings? Yes No if Yes, what type of fillings? _____

Is there anything else you'd like to share with us about your child or your child's health?
_____
_____
_____
_____
_____

Thank you for taking the time to fill this out thoughtfully, thoroughly and legibly. It will assist us in giving your child the best care possible.