Eastside Natural Health Clinic

Pediatric Intake

Please complete this confidential intake form as completely as possible. Thank you.

Patients' name_____ Today's Date_____
Date of birth _____ Age _____ Sex _____ Birthplace _____
Mother's name_____ Father's name_____
Does child live with: θ Mother θ Father θ Both parents θ Other_____
Are there other siblings in the household? θ No θ Yes. Ages?_____
Address _____ City_____ Zip code_____
Home phone _____Work phone _____
How did you hear about our clinic? _____

Major Complaints. Please list in order of importance, when symptoms appeared, and if your child has had these symptoms before:

1. _____
2. _____
3. _____
4. _____

Is your child being treated elsewhere? θ No θ Yes. Please list the names of other providers
_____
_____
Please list any medications your child is taking (including herbs and vitamins):
_____
_____
_____
Allergies to medicines _____

Birth History:

Weight at birth _____ Term: Full ___ Premature _____ Late ____
Length of labor _____
Complications?_____ Where did the birth take place? _____
Did you have any health problems during your pregnancy? θ No θYes. _____

Child's sleep patterns (first year) _____
Food intolerances (in known)? _____
Was your child breastfed? θ No θ Yes. How long?_____ Any difficulties?_____
Was your child fed formula? θ No θ Yes. Which kind?_____How long? _____
What age did your child begin solid foods? _____ What were those foods? _____
_____
Age child began: Sitting _____ Crawling _____ Walking _____ Talking _____

Family Health History. Has anyone in your child's close family suffered from:

____ Diabetes	____ Stroke	____ Heart disease
____ Seizures	____ Allergies	____ High blood pressure
____ Cancer	____ Alcoholism	____ Mental Illness
____ Asthma	____ Addictions	____ Birth defects

Medical History. Please check all complaints that are or have been a part of your child's health history.
P = previously C = currently

P	C		P	C		P	C	
θ	θ	rashes	θ	θ	diarrhea	θ	θ	diabetes
θ	θ	eczema	θ	θ	nightmares	θ	θ	urinary problems
θ	θ	hives	θ	θ	unusual fears	θ	θ	menstrual problems
θ	θ	canker sores	θ	θ	jaundice	θ	θ	neck or back pain
θ	θ	high fevers	θ	θ	asthma	θ	θ	joint pain
θ	θ	change in hearing	θ	θ	sore throats	θ	θ	arthritis
θ	θ	change in vision	θ	θ	excessive fatigue	θ	θ	seizures
θ	θ	frequent colds	θ	θ	colic or gas	θ	θ	night sweats
θ	θ	headaches	θ	θ	excessive fatigue	θ	θ	fainting or dizziness
θ	θ	poor sleeping	θ	θ	heart disease	θ	θ	emotional problems
θ	θ	earaches	θ	θ	cough	θ	θ	cancer
θ	θ	allergies	θ	θ	change in appetite	θ	θ	injuries
θ	θ	constipation	θ	θ	hypoglycemia	θ	θ	surgery

Has your child ever had:
_____ Chicken pox
_____ Measles
_____ Mumps
_____ Rubella
_____ Scarlet fever
_____ Pneumonia
_____ Rheumatic fever
_____ Tonsillitis, no. of times ___
_____ Ear infections, no. of times ___
_____ Other (please list)

Immunizations: Did your child receive a full schedule?_____ Partial?_____ None?_____
If you chose to stop vaccinations, when and why? _____
Please check those vaccines your child has received:

_____ Measles	_____ MMR	_____ HepB
_____ Mumps	_____ Tetanus	_____ Varicella
_____ Polio	_____ Smallpox	_____ Dipththeria
_____ DPT	_____ Influenza	_____ Rotavirus

Others (please list) _____
Any adverse reactions noticed? _____

Lifestyle. Which of the following are part of your child's lifestyle? If so, state how much.

θ Daycare _____
θ Special/restricted diet _____
θ Television _____
θ Computer activity _____
θ Team sports _____
θ Group play _____
θ Alcohol or drugs _____

Diet. Please describe your child's typical daily diet:

_____
_____
_____
_____

Thank you!
We look forward to serving you and your family!