

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: Mother Father Both parents Other _____
Are there other siblings in the household? No 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? No 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? No Yes. _____

Child's sleep patterns (first year) _____

Food intolerances (in known)? _____

Was your child breastfed? No Yes. How long? _____ Any difficulties? _____

Was your child fed formula? No 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 |
| <input type="checkbox"/> <input type="checkbox"/> rashes | <input type="checkbox"/> <input type="checkbox"/> diarrhea | <input type="checkbox"/> <input type="checkbox"/> diabetes |
| <input type="checkbox"/> <input type="checkbox"/> eczema | <input type="checkbox"/> <input type="checkbox"/> nightmares | <input type="checkbox"/> <input type="checkbox"/> urinary problems |
| <input type="checkbox"/> <input type="checkbox"/> hives | <input type="checkbox"/> <input type="checkbox"/> unusual fears | <input type="checkbox"/> <input type="checkbox"/> menstrual problems |
| <input type="checkbox"/> <input type="checkbox"/> canker sores | <input type="checkbox"/> <input type="checkbox"/> jaundice | <input type="checkbox"/> <input type="checkbox"/> neck or back pain |
| <input type="checkbox"/> <input type="checkbox"/> high fevers | <input type="checkbox"/> <input type="checkbox"/> asthma | <input type="checkbox"/> <input type="checkbox"/> joint pain |
| <input type="checkbox"/> <input type="checkbox"/> change in hearing | <input type="checkbox"/> <input type="checkbox"/> sore throats | <input type="checkbox"/> <input type="checkbox"/> arthritis |
| <input type="checkbox"/> <input type="checkbox"/> change in vision | <input type="checkbox"/> <input type="checkbox"/> excessive fatigue | <input type="checkbox"/> <input type="checkbox"/> seizures |
| <input type="checkbox"/> <input type="checkbox"/> frequent colds | <input type="checkbox"/> <input type="checkbox"/> colic or gas | <input type="checkbox"/> <input type="checkbox"/> night sweats |
| <input type="checkbox"/> <input type="checkbox"/> headaches | <input type="checkbox"/> <input type="checkbox"/> excessive fatigue | <input type="checkbox"/> <input type="checkbox"/> fainting or dizziness |
| <input type="checkbox"/> <input type="checkbox"/> poor sleeping | <input type="checkbox"/> <input type="checkbox"/> heart disease | <input type="checkbox"/> <input type="checkbox"/> emotional problems |
| <input type="checkbox"/> <input type="checkbox"/> earaches | <input type="checkbox"/> <input type="checkbox"/> cough | <input type="checkbox"/> <input type="checkbox"/> cancer |
| <input type="checkbox"/> <input type="checkbox"/> allergies | <input type="checkbox"/> <input type="checkbox"/> change in appetite | <input type="checkbox"/> <input type="checkbox"/> injuries |
| <input type="checkbox"/> <input type="checkbox"/> constipation | <input type="checkbox"/> <input type="checkbox"/> hypoglycemia | <input type="checkbox"/> <input type="checkbox"/> surgery |

Has your child ever had:

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Ear infections, |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Pneumonia | no. of times <input type="text"/> |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Other (please list) |
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Tonsillitis, | |
| | no. of times <input type="text"/> | |

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:

- | | | |
|----------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Measles | <input type="checkbox"/> MMR | <input type="checkbox"/> HepB |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Tetanus | <input type="checkbox"/> Varicella |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Smallpox | <input type="checkbox"/> Diphtheria |
| <input type="checkbox"/> DPT | <input type="checkbox"/> Influenza | <input type="checkbox"/> 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.

- | | |
|--|---|
| <input type="checkbox"/> Daycare _____ | <input type="checkbox"/> Team sports _____ |
| <input type="checkbox"/> Special/restricted diet _____ | <input type="checkbox"/> Group play _____ |
| <input type="checkbox"/> Television _____ | <input type="checkbox"/> Alcohol or drugs _____ |
| <input type="checkbox"/> Computer activity _____ | |

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

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