PURE HEALTH
Naturopathic Clinic

Pediatric Intake

Name____ Sex: M or F

Date of birth: ___________________ Age: _____ Grade in School: _______

Address: ____

City:________________ State:______________ Zip:____________

Mother's Name and occupation: ____

Father's Name and occupation: ____

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

Name of Primary Care Physician: ____

Name of Previous or Current Pediatrician: ______________________________________

Reason for today's Office Visit:____

____

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

Has child had any blood work done? If yes, please list what and when:

____

Please list any operations or hospitalizations and year they occurred:

____

____

Please list all medicines and supplements child it taking:

________________________________ ____________________________________

________________________________ ____________________________________

________________________________ ____________________________________

________________________________ ____________________________________

Any known Allergies to food, drugs, environment, animals and their reaction (*e.g. peanuts causes hives*):

____

____

Patient Name:_______________________________ DOB: _______________

Previous medical history

Yes indicates the child gets the problem regularly; **No** indicates the child never had the problem; **Past** 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? ____________

Colds? Yes No Past If has had, how many total? ____________

Strep throat? Yes No Past If has had, how many total? ____________

How many times has the child taken antibiotics:____

What other medicines has the child taken in the past? How often?

____________________________________ ____________________________________

____________________________________ ____________________________________

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

MMR: Yes No Some DPT: Yes No Some

Hep B: Yes No Some Hib: Yes No Some

Chickenpox: Yes No Some Polio: Yes No Some

Other:____

Any reactions to vaccinations? If so, please explain:

____

____

Family history

Allergies: Yes No Obesity: Yes No

Cancer: Yes No Tuberculosis: Yes No

Cardiovascular disease: Yes No Mental Illness: Yes No

Diabetes mellitus: Yes No

Patient Name:______________________________ DOB: ______________

Mother's Pregnancy history

Mother's age at conception:_________

Did she have other children already? Yes No

Mother's Health During Pregnancy

Smoking:	Yes	No	Diabetes:	Yes	No
Coffee:	Yes	No	Nausea/Vomiting:	Yes	No
Recreational drugs:	Yes	No	Emotional Stress:	Yes	No
Preeclampsia:	Yes	No	Length of Labor:	__________	
Vaginal birth:	Yes	No	Traumatic birth:	Yes	No

If the birth was difficult, please explain:

____

____

Child's Birth Weight: :______________ Health of baby at birth:__________________________

Child breastfed: Yes No For how long:_______________________________

When put on formula:___________ Formula used:___________________________________

When was child put on solid food:___________ Child's first foods: _______________________

When did child develop teeth:___________ Walk: _______________ Talk: _____________

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

Patient Name:_______________________________ DOB: _______________

Any particular household stressors child has witnessed or gone through:

____

____

____

Diet

Typical Day's Diet:

Breakfast:____

Snack:____

Lunch:____

Snack:____

Supper:____

Snack:____

Child's favorite foods: ____

____

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 and did that seem to affect their health at all?____

Do you spray pesticides or herbicides around the house?______________________________

Do you use any other chemicals around the house? If yes, please describe ________________

____

Does the child seem particularly sensitive to perfumes or other vapors?____________________

Additional Comments or things the doctor should know**:** __________________________________

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