Natura Medica

THE CENTER FOR NATURAL MEDICINE

Pediatric Intake Form

Name:________________________ DOB_____________________ Age ________ Sex: M or F

Address: ____

City:_________________ State:______________ Zip: ____________

Parents email: Email: ____

Grade in School:_____________________________________

Mother's Name and occupation: ____

Home phone:_________________________ Cell: _______________________________

Father's Name and occupation: ____

Home phone:_________________________ Cell: _______________________________

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

Siblings/ (ages)__________________________, ___________________________, ______________________

Pediatrician's name and city located in:____

Date of last physical: ______________________

Reason for today's Office Visit:____

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

Please list any additional Health Concerns: ____

____

Has child had any blood work done? If yes, please list what (please include copies if available): ___________________

____

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?	__________
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:____

12 Roosevelt Avenue Mystic CT 06355 Tel 860 572-9566 Fax 860 572-7318
www.naturamedicamystic.com

Hearing tests Normal:	Yes	No	Not Tested
Vision Tests Normal:	Yes	No	Not Tested
Any speech impediments:	Yes	No	Past
Learning disabilities:	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: ____

____

Yes= Regular issue; **No**= Never had the issue; Past=had problem in the past, but not recently. Indicate the correct answer.

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	Allergies:	Yes	No
Birth Defects:	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
Urinary Tract infections	Yes	No	Chickenpox	Yes	No
Developmental Delays	Yes	No	Heart Murmur	Yes	No
Heart Defect	Yes	No	Inactivity	Yes	No
Seizure Disorder	Yes	No	Whooping Cough	Yes	No
Ear tubes	Yes	No	Irritability	Yes	No
Scarlet Fever	Yes	No	Frequent High Fevers (>102°F)	Yes	No
Thumb sucking	Yes	No	Until what age?__________		

Review of systems: Please indicate Now (N) or in the Past (P)

Digestion

Bowel Movement _______ X per day: 1-2___ 2-3___ 3-4___ OR X per week: 1-2___ 2-3___ 3-4___

Texture: Dry___ Hard/pellets___ Wet/Loose___ Stools with Mucous___ Blood____

Very dark stools _______ Very light stools _______

Belching_______ Gas / Flatus _______ Nausea / Vomiting _______

Sleep

Wake Easily? Y / N Frequently? Y/N Difficulty Falling Asleep Y / N

Snore Y / N Talk Y / N Grind Teeth Y / N Sleep Walk Y / N

Preferred Sleeping Position____________________

Perspiration

Sweat Easily Y / N Sweat Excessively Y / N Sweat Very Little Y / N

Appetite

Excessive____ Good____ Poor____

Foods child craves strongly_________________________ Foods child dislikes strongly_______________________

Prefers foods Hot__ Warm__ Cold__

Thirst: Excessive __ Good__ Poor__

Prefer drinks: Very Hot___ Hot___ Warm__ Cold__ Ice cold__

Recent Weight Change Y / N

Diet

Foods: Please list in each food group, the foods that your child currently eats. Grain would include all breads, pasta and other related foods.

Meat:		Fruit:		Veg:		Grain:	
	________		________		________		________
	________		________		________		________
	________		________		________		________
	________		________		________		________
	________		________		________		________
	________		________		________		________
Other:	________		________		________		________

Please list any operations or hospitalizations and year occurred:

1. ______________________________

2. ______________________________

3. ______________________________

Please list all prescription and over the counter medications that s/he is currently taking:

Medication	Dose	Date Started	Prescribed By

List vitamins, minerals, herbs, homeopathic remedies that s/he is currently taking:

Supplement	Dose	Date Started

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

____

____

____

____

Typical Day's Diet:

Breakfast:____

Snack:____

Lunch:____

Snack:____

Supper:____

Snack:____

Does the child have any dietary restrictions or follow a particular dietary regimen? If yes, please describe:

____

____

Personal Habits

	hours/week (present)	**hours/week (past)**
Television		
Computer/Video Games		
Video/Movies		

	how much?	**how long for?**
Soda		
Sweets/Candy		
Coffee/Tea		

Does s/he have daily physical activity? Yes No

What type?____

Any particular household stressors the child has witnessed or gone through:

1. ____
2. ____

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 or use other toxic chemicals?

____

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

Family history

Please check the "yes" box, next to each condition, that applies to a family member. Please indicate which family member (e.g. mother, aunt, sister, father) in the relation column and whether this is a current issue (NOW) or previous issue (Past).

CONDITION	YES	RELATION	PAST (P) / NOW (N)	CONDITION	YES	RELATION	PAST (P) / NOW (N)
Allergies				Anemia			
Arthritis				Asthma			
Depression				Diabetes			
Eczema				Epilepsy			
Headaches				Mental Illness			
Cardiovascular Disease				High Cholesterol			
Obesity				Thyroid Disease			
Kidney Disease				Suicide			
Tuberculosis				Other			
Other				Other			
Cancer							
Type?							

Mother's Pregnancy History:

Age at conception:_________

Did she have other children already? Yes No

Mother's Health During Pregnancy

Smoking: Yes No

Coffee: Yes No

Recreational drugs: Yes No

Preeclampsia: Yes No

Diabetes: Yes No

Nausea/Vomiting: Yes No

Emotional Stress: Yes No

Threatened Abortion Yes No

Birth:

Vaginal birth: Yes No

Induction (pitocin): Yes No

Traumatic birth: Yes No

Length of Labor: __________

If the birth was difficult, please explain: ____________________

Premature Yes No

Past Due Yes No

Cord around neck Yes No

Breech Delivery Yes No

Caesarian section with prior delivery Yes No

Scheduled Caesarian Yes No

Any medications during labor, please list: ____________________

Neonatal:

Child's Birth Weight: :______________ Birth Length: ____________________

Health of baby at birth:____

APGAR: _________________________________ Rh incompatibility: ________________________

Failure thrive: ___________________________

Child breastfed: Yes No For how long:________________________

Any difficulties nursing: ___________________________________

When put on formula:_________________ What formula was used:_______________________

When was child put on solid food:______________________

When did child walk:___________________ Talk:________________

When did child develop teeth:________________________

PLEASE check any of the following that apply

- Poor Posture: sitting /standing
- Difficulty reading/ learning
- Loud voice (outside voice all the time)
- Fidgets
- Impulsive
- Can not tolerate tags, seams in socks
- Will only wear certain clothes
- Doesn't like hair cut/brushed
- Doesn't like baths
- "picky eater"
- Sensitive to touch, smell, light, noise
- Can't tolerate crowds
- Loves or hates amusement rides
- Punches/ bites (parents, siblings, other)
- likes dislikes hugs
- likes or dislikes finger paints/getting messy
- Increased/ decreased response to pain, temp etc
- Bumps into things/people
- Poor balance " Clumsy"
- Has Car sickness

Note Any Additional Comments below:

____

____

____

____

____