

**Providence Wholistic Healthcare**  
*Integrative Natural Family Medicine*  
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## Pediatric Intake Form

**Welcome!** It is our goal to provide your child with the best possible complementary natural health care. In order to serve you optimally, please answer the following questions about your child. Thank you!

Child's Name \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ Zip \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Pronouns \_\_\_\_\_ Phone \_\_\_\_\_  
 Names: Parent 1 \_\_\_\_\_ (Cell #) \_\_\_\_\_  
 Parent 2 \_\_\_\_\_ (Cell#) \_\_\_\_\_  
 Parent Email: \_\_\_\_\_ Other Guardian \_\_\_\_\_  
 How did hear about this clinic \_\_\_\_\_ Referred By \_\_\_\_\_  
 Person to be notified in case of an emergency \_\_\_\_\_  
 Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_

**List (1) all health problem(s) that are the reason for this appointment, (2) other health concerns:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Does your child have a contagious illness at this time? Y N If yes, what? \_\_\_\_\_

**Is your child allergic or hypersensitive to any of the following (Y or N and list known specifics):**

Drugs/Medication Y N \_\_\_\_\_  
 Environmental Y N \_\_\_\_\_ Worst Season(s) \_\_\_\_\_  
 Foods Y N \_\_\_\_\_

<b>Medications:</b>	Now	Past	Frequency	<b>Supplements:</b>	Now	Past	Dose
Aspirin	_____	_____	_____	Vitamins	_____	_____	_____
Tylenol	_____	_____	_____	Minerals	_____	_____	_____
Antibiotics	_____	_____	_____	Fluoride	_____	_____	_____
Decongestants	_____	_____	_____	Herbs	_____	_____	_____
Other	_____	_____	_____	Other	_____	_____	_____

**Childhood Illnesses Y (yes) N (no)**

_____ Chicken Pox	_____ Scarlet Fever	_____ Mononucleosis
_____ Measles	_____ Rheumatic Fever	_____ Ear Infections
_____ Mumps	_____ Strep Throat	_____ Tonsillitis
_____ Rubella	_____ Pneumonia	_____ Other _____

**Childhood Immunizations: (circle types; notes any adverse reactions)**

HIB	DPT	Measles/Mumps/Rubella	Hepatitis B	HPV
Polio	Varicella	Tuberculosis Test	Influenza	Other _____

**Hospitalizations/Surgeries/Accidents/Serious Injuries:** (describe each incident and give dates):

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**Childhood Testing: Has your child had any of the following tests? When? Diagnosis?**

EEG (electroencephalogram) \_\_\_\_\_

Psychological evaluation \_\_\_\_\_

Hearing tests \_\_\_\_\_

Speech/Language tests \_\_\_\_\_

Neurological evaluation \_\_\_\_\_

**Family History:** Identify family members who have, or have had, any of the following: M, F, PGM, etc

_____ Alcoholism	_____ Epilepsy	Other _____
_____ Allergies	_____ Heart Disease	Other _____
_____ Anemia	_____ Hearing Loss	
_____ Arthritis	_____ High Blood Pressure	Does your child have any of these?
_____ Asthma	_____ Hypoglycemia	_____
_____ Birth Defects	_____ Mental Illness	_____
_____ Cancer	_____ Obesity	
_____ Diabetes	_____ Stroke	
_____ Eczema/Dermatitis	_____ Thyroid Disorder	

**Infant's/Child's/Adolescent's Health History**

Now	Past	Never		Now	Past	Never	
_____	_____	_____	Acne	_____	_____	_____	Epilepsy/Seizures
_____	_____	_____	Allergies	_____	_____	_____	Fatigue
_____	_____	_____	Anemia	_____	_____	_____	Frequent Infections
_____	_____	_____	Bed Wetting	_____	_____	_____	Headaches
_____	_____	_____	Birth Defects	_____	_____	_____	Heart Murmur
_____	_____	_____	Colic	_____	_____	_____	High Fever
_____	_____	_____	Constipation	_____	_____	_____	Hyperactivity
_____	_____	_____	Cough/Wheeze	_____	_____	_____	Insomnia
_____	_____	_____	Cradle Cap	_____	_____	_____	Jaundice
_____	_____	_____	Depression	_____	_____	_____	Learning Disorder
_____	_____	_____	Diarrhea	_____	_____	_____	Moodiness
_____	_____	_____	Dizzy Spells	_____	_____	_____	Stuffy Nose
_____	_____	_____	Earaches	_____	_____	_____	Vomiting Spells
_____	_____	_____	Eczema	_____	_____	_____	Other _____

**What is your child's general disposition?** \_\_\_\_\_

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**Prenatal/Birth/Feeding History**

1. Mother’s health during pregnancy for this child (check, then describe below)

_____ Age	_____ Trauma/Injury	_____ Alcohol Consumption #/wk _____
_____ Bleeding	_____ Stress	_____ Drugs _____ Medications
_____ Nausea	_____ High Blood Pressure	_____ Smoking _____ Other _____
_____ Illness	_____ X-Rays	_____ Toxemia

2. Term: Full \_\_\_\_\_ Premature \_\_\_\_\_ Late \_\_\_\_\_ Birth Weight \_\_\_\_\_

3. Was pregnancy easy? \_\_\_\_\_ Difficult? \_\_\_\_\_

Explain \_\_\_\_\_

4. Place of birth? Hospital \_\_\_\_\_ Home \_\_\_\_\_ Clinic \_\_\_\_\_ Other \_\_\_\_\_

5. Interventions at labor/birth:

\_\_\_\_\_ Pitocin \_\_\_\_\_ Epidural \_\_\_\_\_ Demerol or other pain Rx

\_\_\_\_\_ Forceps \_\_\_\_\_ C-Section \_\_\_\_\_ Vacuum extraction

6. Feeding: Breast fed Y N How long? \_\_\_\_\_ Cow’s milk Y N How long? \_\_\_\_\_

Formula fed Y N How long? \_\_\_\_\_ Type of formula \_\_\_\_\_

7. Age Solid Food Begun \_\_\_\_\_ What foods? \_\_\_\_\_

Favorite Foods \_\_\_\_\_

**Sample Daily Diet:** (choose a typical day and include food and liquids)

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snack \_\_\_\_\_

**Social History:**

1. Parents: Married \_\_\_\_\_ Partnership \_\_\_\_\_ Separated \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_

Parent’s Occupation \_\_\_\_\_ Full / Part Time

Parent’s Occupation \_\_\_\_\_ Full / Part Time

2. Other Guardian \_\_\_\_\_ Relationship \_\_\_\_\_

3. Others residing in home \_\_\_\_\_ Relationship \_\_\_\_\_

4. Daycare/Preschool/School \_\_\_\_\_ Where \_\_\_\_\_

How many hours each day \_\_\_\_\_ Days of the week \_\_\_\_\_

5. Pets at home: \_\_\_\_\_

SIBLING(S): NAME

AGE

HEALTH PROBLEMS

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

## REVIEW OF BODY SYSTEMS

Y: a condition now    P: a condition of the past    N: Never

### MENTAL/EMOTIONAL

Mood Swings	Y P N	Anxiety/nervousness	Y P N
Irritability	Y P N	Cries easily	Y P N
Hyperactivity	Y P N	Unusual fears	Y P N
Introvert/extrovert	Y P N	Sleep Problems	Y P N
Motion/car sickness	Y P N	Nightmares	Y P N

### ENDOCRINE

Heat/cold intolerance	Y P N	Fatigue	Y P N
Excessive thirst	Y P N	Excessive hunger	Y P N
Low blood sugar	Y P N	High blood sugar	Y P N

### SKIN

Rashes	Y P N	Eczema, Hives	Y P N
Acne, Boils	Y P N	Itching	Y P N

### HEAD

Headaches	Y P N	Head Injury	Y P N
Dizzy spells	Y P N	High fevers	Y P N

### EYES

Glasses or contacts	Y P N	Tearing or dryness	Y P N
Eye pain/strain	Y P N		

### EARS

Earaches	Y P N	Impaired hearing	Y P N
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### NOSE AND SINUSES

Frequent colds	Y P N	Noses Bleeds	Y P N
Stuffiness	Y P N	Hay fever	Y P N
Sinus problems	Y P N	Loss of smell	Y P N

### MOUTH AND THROAT

Frequent sore throat	Y P N	Canker sores	Y P N
Breath odor	Y P N		

### RESPIRATORY

Cough	Y P N	Wheezing	Y P N
Asthma	Y P N	Bronchitis	Y P N

### CARDIOVASCULAR

Heart disease	Y P N	Murmurs	Y P N
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### URINARY

Frequent urination	Y P N	Bed wetting	Y P N
Kidney disease	Y P N	Bladder infections	Y P N

Y= condition now    P= a condition in the past    N= never had

**GASTROINTESTINAL**

Belching/passing gas	Y P N	Stomach aches	Y P N
Constipation	Y P N	Diarrhea	Y P N
Bowel Movements	How often _____		

**MUSCULOSKELETAL**

Joint pain/stiffness	Y P N	Muscle spasms/cramps	Y P N
Broken bones	Y P N		

**BLOOD/PERIPHERAL VASCULAR**

Anemia	Y P N	Easy bleeding/bruising	Y P N
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Do you have any other health concerns you would like to discuss? Please explain

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Is there any information about your child's health that you would like to add?

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*Welcome! We're glad to be of service for you and your child!*