



**NATUROPATHIC PEDIATRIC INTAKE FORM**

Patients Name: \_\_\_\_\_

Age: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Sex: M F

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

How did you hear about this clinic? \_\_\_\_\_

1) Primary reason for coming to the clinic? \_\_\_\_\_  
\_\_\_\_\_

2) When did it first occur? \_\_\_\_\_

3) What makes it better? \_\_\_\_\_

4) What makes it worse? \_\_\_\_\_

5) Have you consulted any other health care practitioners regarding this condition? Y N

Please explain therapy and results: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6) Please list any other health concerns you have at this time: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY HEALTH HISTORY**

7) Please indicate whether there is any history of the following conditions in your family and give details below:

Heart Disease	Hypertension	Cancer	Diabetes	Arthritis
Allergies	Birth Defects	Tuberculosis	Mental Illness	
Multiple Sclerosis	Auto-immune Disorders	Asthma	Psoriasis	

Eczema or any other conditions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8) Please indicate if any siblings have a similar condition or any listed above: \_\_\_\_\_  
\_\_\_\_\_

**CHILD'S HEALTH HISTORY**

9) Mother's age at child's birth: \_\_\_\_\_ Father's age: \_\_\_\_\_

10) Number of previous pregnancies by natural mother, miscarriages or complications  
\_\_\_\_\_  
\_\_\_\_\_

11) Please indicate whether any of the following conditions were present during the pregnancy:

Bleeding            Nausea            Illness            Hypertension    Medication  
Diabetes            Physical or Emotional Trauma    Smoking            Alcohol Drug Consumption

12) Was the birth process            Vaginal            C-Section  
Was any medical intervention used: Y    N    (eg forceps, c-section, epidural anesthesia etc.)  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

13) Term:            Full\_\_\_\_            Premature\_\_\_\_            Late\_\_\_\_            Weight\_\_\_\_\_

14) Was the child breast fed within the first 10 hours after birth? Y    N

15) Was the child breast fed at all?    Y    N    How long?\_\_\_\_\_

16) If formula was given to the child, which kind (milk, soya)\_\_\_\_\_

17) Age at which solid food were introduced\_\_\_\_\_

18) Did your child require any medical attention, hospitalization or medication as an infant (before age 2) Y    N

Please list all surgeries, their approximate dates, why they were performed and if you feel they were successful \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

20) Please circle the conditions that your child has been vaccinated for:

Measles    Mumps    Polio    DPT    MMR    Tetnus    Diphtheria    Influenza    Influenza    Chicken Pox  
Meningitis  
Other \_\_\_\_\_

21) Has your child had the following problems?    Jaundice            Colic            Fever  
Blue Baby            Diarrhea            Constipation            Seizures            Birth Defects            Rashes  
Cerebral Palsy            Birth injuries            Pneumonia            Frequent colds  
Tonsillitis            Ear infection            Unusual weight gain/loss  
Other \_\_\_\_\_

22) List any medication your child has been on (asprin, Tylenol, decongestants, antibiotics, anti-histamines) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

23) List any known allergies your child may have (environmental, food, medications etc.)

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24) Please mention any other information which has not already been mentioned that you feel may be pertinent to the treatment of your child

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