PEDIATRIC NATUROPATHIC NEW PATIENT INTAKE

Patient Information

Name:

Birthday: Age: Sex: ☐ M ☐ F

Address:

City: State: Zip:

Mother's Name and Occupation:

Father's Name and Occupation:

Parents are: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced

Whom may we thank for referring you to our office?

Concerns

Reason for office visit?

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

Regular Pediatrician name and city located in:

Medicine & Supplements

List all Medicines (from drugstore or prescription) child is on now:

MEDICATION NAME	DOSE	REASON	STARTED?

List all Supplements and Homeopathics child is taking:

SUPPLEMENT NAME	DOSE	REASON	STARTED?

Past Medical History

Last time the child had blood work done and with what physician?

List all Surgeries and Hospitalizations? Please include the date.

Any known Allergies to food, drugs, environment, and animals? Include type of reaction:

Indicate **Y (yes)** if the child gets the problem regularly; **N (no)** if the child never had the problem; and **P (past)** if the child had the problem in the past, but not recently.

Ear Infections:	Y	N	P	If has had, how many total:
Colds:	Y	N	P	If has had, how many total:
Strep Throat:	Y	N	P	If has had, how many total:

How many times has the child taken antibiotics?

What other medications has the child taken and how often?

Hearing Tests Normal:	Y	N	Not Tested
Vision Tests Normal:	Y	N	Not Tested
Speech Impediments:	Y	N	Past
Learning Impediments:	Y	N	Past

Vaccination History

Please circle 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	**Chicken Pox:**	Yes	No	Some	**Polio:**	Yes	No	Some

Other:

Any reactions to vaccinations? If so, please explain:

Family History

Please ☑ If a family member currently has, or has had, any of the following conditions listed below.

	CONDITION NAME	WHO?		CONDITION NAME	WHO?
☐	Allergies		☐	Heart Disease	
☐	Asthma		☐	Mental Illness	
☐	Cancer		☐	Obesity	
☐	Diabetes		☐	Other	

Mother's Pregnancy History

Age at Conception:		Did she have other children already?	Y N	How Many:	
Smoking:	Y N	Coffee:	Y N	Alcohol / Drugs:	Y N
Nausea/Vomiting:	Y N	Emotional Stress:	Y N		
Preeclampsia:	Y N	Gestational Diabetes:	Y N		
Length of Labor:		Vaginal Birth or C-Section (circle one)			
Traumatic Birth:	Y N	If yes, please explain:			

Health History of Child

Weight at birth:		Health of baby at birth:			
Child breastfed:	Y N	For how long?		When put on formula:	
What formula was used:		When was child put on solid food:			
When did child walk:		Talk:		Develop Teeth:	
Jaundice as baby:	Y N	Colic:	Y N		
Cradle Cap:	Y N	Anemia:	Y N		
Eczema or Psoriasis:	Y N	Asthma or Wheezing:	Y N		
Diarrhea:	Y N	Warts:	Y N		
Constipation:	Y N	Nightmares:	Y N		
Finicky Eating:	Y N	Bed-wetting:	Y N		
Poor Teeth:	Y N	Tantrums:	Y N		
Chronic Sniffles:	Y N	Disobedient:	Y N		
Bad Foot Odor:	Y N	Fears or Phobias:	Y N		
Very Sweaty Baby/Child:	Y N	Diaper Rash:	Y N		
Hyperactivity:	Y N	Early Puberty:	Y N		

Growing Pains:	Y	N	Stomach Aches:	Y	N

Any particular household stressors child has witnessed or gone through:

Toxin Exposure

Has the child ever lived near a refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to?

Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health at all?

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

Do you spray pesticides, herbicides or other chemicals around your home?

Typical Day's Diet

Breakfast:

Lunch:

Dinner:

Snacks:

Drinks: Water: Soda:

Dairy: Soy: Other:

How often do you and your child each out weekly? What restaurants do you frequent?

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Parent/Guardian Signature: _____ Date: _____

THE FOLLOWING TREATMENTS ARE OFFERED AT ASULA, PLEASE (CIRCLE) *ANY OF INTEREST TO YOU.*

CHIROPRACTIC **ACUPUNCTURE** **MASSAGE** **NATUROPATHY** **AYURVEDA**

♥ WELCOME TO OUR CLINIC ♥