well
naturopathic and chinese medicine

pediatric intake form

patient's name:_____ date:_____

address:_____

city: _____ state: _____ zip: _____

telephone (home): _____ (parent's work): _____

parent's email address: _____

age: _____ date of birth: _____ gender: female / male

how did you hear about this clinic? _____

name of pediatrician: _____ phone:_____

most important health concerns:

1)_____

2)_____

3)_____

4)_____

medications (please circle)

aspirin	decongestants	antibiotics
tylenol	anti-histamine	ibuprofen

other:_____

allergies to medications: _____

medical history (please circle)

chicken pox	scarlet fever	tonsillitis	frequent colds
measles	pneumonia	ear infections	rheumatic fever
mumps	rubella	strep throat	

other:_____

family history

is there a family history of any of the following? (please circle)

heart disease	diabetes	birth defects	allergies
hypertension	arthritis	tuberculosis	asthma
mental illness	osteoporosis	cancer	

other:_____

immunizations

____ mmr	____ dpt	____ chicken pox	____ small pox
____ measles	____ diphtheria	____ h. influenza	____hepatitis b
____ mumps	____ tetanus	____ rubella	____ polio

others:_____

adverse reactions: yes / no

has your child ever had any of the following? when? results?

electroencephalogram (eeg): _____

psychological evaluations: _____

hearing test: _____

speech/language tests: _____

injuries/surgeries/hospitalizations:_____

_____

_____

prenatal history

mother's age at child's birth: _____

mother's health during pregnancy:

____ bleeding	____ nausea	____ physical or emotional trauma
____ illnesses	____ hypertension	____ cigarettes, alcohol, drug consumption
____ medications	____ diabetes	____ thyroid problems

birth history

term: full / premature / late length of labor: _____

any complications? _____

did you child have any of the following problems shortly after birth?

rashes	birth injuries	blue baby	colic	birth defects
jaundice	seizures	cerebral palsy	fever	

other:_____

breast fed: y / n how long? _____ formula: y / n type: milk / soy / other

age began solids:_____

age began: sitting _____ crawling _____ walking _____ talking _____

has your child experienced any of the following: (please circle)

hives	burning urine	bloody urine	eczema
bleeding gums	heart murmur	nervousness	hair loss
nose bleeds	vomiting spells	sleep problems	asthma
acne	anemia	night sweats	high fevers
jaundice	sensitivity to light	chronic rashes	sore throats
diarrhea	hearing loss	easy bruising	cough
flat feet	loss of appetite	body/breath odor	constipation
allergies	stomach aches	unusual fears	excessive fatigue
nightmares	frequent colds	bleeding tendency	frequent urination
wheezing	joint pains	dizzy spells	

please describe your child's typical daily diet:

breakfast:_____

lunch:_____

dinner:_____

snacks:_____

drinks: _____