1785 W SR 89A, Suite 3B, Sedona, AZ 86336
928-282-4559 (p)
SedonaNaturopathic.net

Pediatric Intake Form

Patient Name: ______________________________ **DOB:** ________

Sex (m/f): ___ **Grade of School:** ____
Mother's Name and Occupation: ______________________________

Father's Name and Occupation: ______________________________

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

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: ______________________________

Last time you had blood work done and with what physician: ______________________________

____

List All Surgeries & Hospitalizations, including date occurred:

1) ______________ 4) ______________

2) ______________ 5) ______________

3) ______________ 6) ______________

List All medicines (from drugstore or prescription) child is on now:

1) ______________ 4) ______________

2) ______________ 5) ______________

3) ______________ 6) ______________

List all supplements child is taking:

1) ______________ 4) ______________

2) ______________ 5) ______________

3) ______________ 6) ______________

Any known Allergies to food, drugs, environment, animals: ______________________________

____

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Previous Medical History

YES (Y) indicates the child gets the problem **regularly; NO (N)** indicates the child **never** had the problem**; PAST (P)** indicates the child had the problem in the **past, but not recently. Please circle the correct one for your child.**

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 medicines has the child taken and how often:

1) ______________________________ 3) ______________________________

2) ______________________________ 4) ______________________________

Hearing Tests Normal: Yes No Not Tested

Vision Tests Normal: Yes No Not Tested

Speech Impediments: Yes No Past

Learning Impediments: Yes No Past

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

Other: ______________________________

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Any reactions to vaccinations? If so, please explain: ______________________________

____

____

Family History:

Allergies:	Y N P	**Obesity**:	Y N P	**Cancer**:	Y N P
Tuberculosis:	Y N P	**Mental Illness**:	Y N P		
Cardiovascular Disease:	Y N P	**Diabetes mellitus**:	Y N P		

Mother's Pregnancy History:

Age at conception: ________ **Did she have other children already**? Yes No

Health During Pregnancy:

Smoking:	Y N	**Diabetes**:	Y N	**Coffee**:	Y N
Nausea/Vomiting:	Y N	**Recreational Drugs**:	Y N	**Emotional Stress**:	Y N
Preeclampsia:	Y N	**Length of Labor**:	______	**Vaginal Birth**:	Y N
Traumatic Birth:	Y N				

If the birth was difficult, please explain: ______________________________

____

Health of baby at birth: ______________________________

____

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Health History of Child:

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:**	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/Phobia:**	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:

1) ______________________ 2) ______________________

3) ______________________ 4) ______________________

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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: ______________________________

____

Allergies

List all known Allergies (food, environment): ______________________________

____

____