Nature Cures Clinic, llc.

PEDIATRIC INTAKE FORM (Birth- 10 years)

Patient's name _____ Date of first visit _____

Age _____ Date of Birth _____ Gender: Female_____ Male _____

Mother's name _____ Father's name _____

Address _____ City _____ State _____ Zip _____

Phone # (home) (_____)_____ Parents work # (_____)_____

Parents e-mail address _____

How did you hear about this clinic?

Name of Dr's Office/Hospital/Clinic where your child's health records are kept

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Reason for referral or presenting problems _____

_____

MEDICATIONS	Now	Past		Now	Past
Aspirin	_____	_____	Antibiotics	_____	_____
Tylenol	_____	_____	Anti-histamine	_____	_____
Decongestant	_____	_____	Other	_____	_____
Ibuprofin	_____	_____	Allergies to medicine	_____	

MEDICAL HISTORY

_____	Chicken pox _____	Scarlet fever	_____	Tonsillitis, approx.no. _____	
_____	Measles	_____ Pneumonia	_____	Ear infections, no. _____	
_____	Mumps	_____ Frequent colds		Other (please list)	
_____	Rubella	_____ Rheumatic fever		_____	

Has your child had any of the following test?	When	Where	Results
Electroencephalogram _____			
Psychological evaluation _____			
Hearing _____			
Speech/Language _____			
Injuries/sugInjuries/Surgeries/Hospitalizations (please list) _____			
_____			

IMMUNIZATIONS

_____ Measles _____ Polio _____ MMR _____ Smallpox
_____ Mumps _____ DPT _____ Tetanus _____ Influenza
_____ Diphtheria

Others (list) _____

Any adverse reactions? Y N What? _____

FAMILY HISTORY

_____ Heart disease _____ Diabetes _____ Birth Defects
_____ Hypertension _____ Arthritis _____ Tuberculosis
_____ Cancer _____ Allergies _____ Mental illness

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications?

Mother's age at child's birth? _____
Mother's health during pregnancy?

_____ Bleeding _____ Physical or emotional trauma
_____ Nausea _____ Cigarettes, alcohol, drug consumption
_____ Illnesses _____ Medications
_____ Hypertension _____ Thyroid Problems _____ Diabetes

BIRTH HISTORY

Term: Full _____ Premature _____ Late _____ Weight at birth _____

Lenth of labor _____ Complications? _____

Did your child have any of the following problems shortly after birth?

_____ Birth defects _____ Birth injuries _____ Blue baby
_____ Cerebral palsy _____ Seizures _____ Jaundice
_____ Colic _____ Fever _____ Rashes

Other (explain) _____

Child's sleep patterns (first year) _____

Food intolerances (if any) _____

Feeding: Breast fed? _____ How long? _____ Formula? _____ milk/soy _____

Age began solids _____ Which foods? _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS (mark **Y** if current, **P** significant past symptom)

_____ Hives	_____ Burning of urine	_____ Bloody urine
_____ Eczema	_____ Frequent urination	_____ Cries easily
_____ Bleeding gums	_____ Heart murmur	_____ Nervous
_____ Nose bleeds	_____ Vomiting spells	_____ Sleep problems
_____ Acne	_____ Anemia	_____ Night sweats
_____ High fevers	_____ Stomach aches	_____ Sensitive to light
_____ Chronic rash	_____ Jaundice	_____ Body/breath odor
_____ Hearing loss	_____ Easy bruising	_____ Motion/Car sickness
_____ Diarrhea	_____ Flat feet	_____ No appetite
_____ Sore throat	_____ Constipation	_____ Nightmares
_____ Headaches	_____ Gas	_____ Canker sores
_____ Frequent colds	_____ Bleeding Tendency	_____ Unusual fears
_____ Wheezing	_____ Joint pains	_____ Excessive fatigue
_____ Cough	_____ Dizzy spells	_____ Hair loss

DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks :_____

To Drink: _____

Thank you. We look forward to helping your child in any way we can.