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Doctor of Naturopathic Medicine

Pediatric Patient Health Intake

Today's Date: _____

Patient's Name: _____
(Last) (First) (Middle)

Age: _____ Birthdate: _____ SS#: _____ Gender: M F
(Disclosure of your social security number is voluntary and optional)

Parent's Names: _____
(Mother) (Father)

Name of Gaurdian: _____

Living with: _____ Relationship: _____

Address: _____
(Street, City, State, Zip)

Mailing Address (if different): _____
(Street, City, State, Zip)

E-mail address: _____

Phone(s): _____
(Home) (Work) (Other)

School: _____

Grade in school: _____ School phone: _____

Emergency contact: _____
(Name) (Phone)

Relationship: _____

How did you learn about my practice? _____

Your child's primary care physician: _____
(Physician's Name)

Address: _____

Reason for today's visit: _____

Please list known ALLERGIES to medication, food, or environment: _____

MEDICATIONS

	Now	Past		Now	Past
Antibiotics	_____	_____	Ibuprofen	_____	_____

Decongestants _____
Anti-histamine _____
Inhalers _____

Aspirin _____
Tylenol _____
Insulin _____

Others: _____

List all current medications, dosage, and reason for taking (or attach a list)

List all current vitamins/supplements/herbs/homeopathics, dosage, and reason for taking (or attach a list)

MEDICAL HISTORY

Childhood illnesses (Y=yes, N=never, ?=not sure)

Measles (14-day Rubeola) _____

Frequent colds _____

Pneumonia _____

Mumps _____

Strep throat _____

Tonsillitis _____

Rubella (3-day German measles) _____

Scarlet Fever _____

Ear Infections _____

Chickenpox _____

Rheumatic Fever _____

Diabetes _____

Skin rashes _____

Herpes _____

Chronic diarrhea or constipation _____

Other (please list) _____

IMMUNIZATIONS

MMR (measles, mumps, rubella) _____

Chickenpox _____

Influenza (flu) _____

DPT (diphtheria, pertussis, tetanus) _____

Tetanus _____

Hepatitis _____

Polio _____

Others (please list) _____

SURGERIES

Tonsillectomy _____

Ear tubes _____

Appendix _____

Other (please list) _____

SPECIAL EVALUATIONS

Has your child ever had any of the following exams or tests? Please state when, where, and results.

Hearing _____

Speech/language _____

Allergy testing _____

Psychological evaluation _____

Dental exam/cleaning _____

Vision check _____

Other _____

FAMILY HISTORY (mother/father/siblings)

Heart disease _____ Birth defects _____ Thyroid problems _____
Hypertension _____ Allergies _____ Bowel disorders _____
Diabetes _____ Eczema _____ Tuberculosis _____
Depression _____ Rheumatoid arthritis _____ Cancer (type) _____
Mental illness (type) _____
Other _____

PRENATAL/BIRTH/NEONATAL HISTORY

Mother's health during pregnancy

Hypertension _____ Smoking, alcohol, drug use _____
Diabetes _____ Physical or emotional trauma _____
Thyroid problems _____ Illnesses _____
Medications _____

Mother's age at birth of child: _____

Term: Full _____ Premature _____ Late _____ Birth wt: _____ lbs _____ oz

List complications during labor or at birth: _____

Neonatal complications (ie: colic, jaundice, heart murmur) _____

DEVELOPMENTAL HISTORY

Child's sleep pattern first year _____

Bed wetting _____

Breast Fed: Y N How long? _____ Formula: Cow milk _____ Soy _____ Other _____

Age solid foods introduced: _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS (Y=yes, P=past, N=never)

Frequent headaches	Y	P	N	Frequent vomiting	Y	P	N
Dizzy spells	Y	P	N	Frequent diarrhea	Y	P	N
Motion/car sickness	Y	P	N	Freq. constipation	Y	P	N
High fevers	Y	P	N	Stomach aches	Y	P	N
Siezuers	Y	P	N	Excessive gas	Y	P	N
Frequent colds	Y	P	N	No appetite	Y	P	N
Ear pain/itching	Y	P	N	Body/breath odor	Y	P	N
Hearing loss	Y	P	N	Burning on urination	Y	P	N
Frequent sore throat	Y	P	N	Frequent urination	Y	P	N
Nose bleeds	Y	P	N	Bloody urine	Y	P	N
Canker sores	Y	P	N	Anemia	Y	P	N
Bleeding gums	Y	P	N	Easy bleeding	Y	P	N
Easy bruising	Y	P	N	Excessive fatigue	Y	P	N
Wheezing	Y	P	N	Night sweats	Y	P	N
Frequent cough	Y	P	N	Sensitive to light	Y	P	N

Hives Y P N
Eczema Y P N
Chronic rash Y P N
Acne Y P N
Joint pain Y P N
Flat feet Y P N

Cries easily Y P N
Nervous Y P N
Sleep problems Y P N
Nightmares Y P N
Unusual fears Y P N

DIET

Please describe your child's typical daily diet.

Glasses of water/day: _____

Breakfast: _____

Lunch: _____

Snacks/beverages: _____

Dinner: _____

Does your child have any food intolerances that you know of? Y N

If yes, please explain: _____

Naturopathic Medical Consent: I, the undersigned, consent to naturopathic care and treatment of my child, _____ by Meghan Van Vleet, ND.
(Child's Name)

Financial Agreement: I, the undersigned, acknowledge that I am financially responsible for all charges, and agree to pay Meghan Van Vleet, ND in accordance with her regular rates and terms. All payment is due at time of service, unless alternative arrangements have been made prior to services being rendered. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I agree to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Meghan Van Vleet, ND to release information necessary to secure payment.

I, the undersigned, certify that the information I have supplied is correct and accurate to the best of my knowledge.

Parent/guardian name: _____
(Print)

Signature: _____ Date: _____

Thank You.