

*Childhood Immunization 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: \_\_\_\_\_

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**FAMILY HISTORY**

Are there any allergies to dairy or wheat in your family? Y / N  
Have there been any negative neurological outcomes to vaccines? Y / N  
Are there any neurological diseases in your family? Y / N

**GESTATIONAL HISTORY**

Was the mother given any vaccinations prior or during pregnancy? Y / N  
What illnesses did the mother have during pregnancy? \_\_\_\_\_  
Did the mother smoke during pregnancy? Y / N  
What was the child's gestational age at birth? \_\_\_\_\_ weeks  
The birth was: vaginal / cesarean  
Were antibiotics given to the mother or child at birth? Y / N

**CHILD HEALTH HISTORY**

Has the child received any vaccines yet? Y / N Which ones at what ages? \_\_\_\_\_

Is the child meeting developmental milestones? Y / N

Is the child breastfed? Y / N

Does the child eat food yet? Y / N What foods? \_\_\_\_\_

Does the child have any known allergies or sensitivities to anything? Y / N

If yes, what? \_\_\_\_\_

Has the child ever been given antibiotics? Y / N

What supplements does the child take? \_\_\_\_\_

Does the child suffer from any type of skin rash? Y / N

What is the child's ethnicity? \_\_\_\_\_

**ENVIRONMENTAL HISTORY**

Is there any smoking in the house? Y / N

Does anyone in the family smoke? Y / N

What is the profession of the parents? \_\_\_\_\_

Does the child attend daycare? Y / N

Where does the child live (ie: on a farm)? \_\_\_\_\_

How many people are in the household? \_\_\_\_\_

Does the child have siblings? Y / N

Ages of siblings: \_\_\_\_\_

Siblings vaccinated for anything? Y / N If yes, what? \_\_\_\_\_

Are the siblings in school? Y / N

Will the child be travelling outside of the United States at any time? Y / N

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**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.*