Good News Naturopathic Clinic
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Pediatric Intake Form

Date: _____

Patient Last Name: _____ First Name: _____

DOB: _____ Age: _____ Sex: M F SSN: _____

Street Address: _____

City: _____ State: _____ Zip: _____

PARENT/GUARDIAN CONTACT INFORMATION:
Name:_____ Relationship: _____ Phone: _____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Insured? Y N Insurance Provider: _____

Preferred number to reach you: _____ OK to leave voicemail? Y N

Parent's Email address: _____

EMERGENCY CONTACT INFORMATION (*in the event parent/guardian cannot be reached*)

Name: _____ Relationship: _____ Phone: _____

How did you hear about us?

- Referral from Health Care Provider – Name: _____
- Patient Referral – Name: _____
- Nutrition Workshop Internet Search Other (please specify): _____

When did your child's last receive health care, and for what reason?

_____
_____
_____

Reason for today's visit: _____

Has your child been seen by any other doctor(s) for this health concern? Y P N

Please list your child's primary health concerns/goals (in order of importance):

1. _____
2. _____
3. _____
4. _____
5. _____

Please list all MEDICATIONS your child is currently taking, including over-the-counter medications.

 Child does not currently take any medications.

Medication	**Reason**	**Date/year started?**	**Dose/Frequency**	**Helpful? Y or N**
1.				
2.				
3.				
4.				
5.				

Please list all SUPPLEMENTS your child is currently taking, including vitamins, minerals, herbal, and others.

 Child does not currently take any supplements.

Supplement Name (ex: Vitamin B12)	**Supplement Brand** (ex: Nature's Way)	**Date/year started?**	**Dose/Frequency**	**Helpful? Y or N**
1.				
2.				
3.				
4.				
5.				

Please list any known drug, food or environmental allergies:

_____

_____

_____

MOTHER'S PREGNANCY HEALTH

Age at conception: _____ First pregnancy? Y N If not, pregnancy # _____

Smoke	Y N	Preeclampsia	Y N
Coffee	Y N	Diabetes	Y N
Recreational Drug Use	Y N	Emotional Stress	
Nausea/Vomiting	Y N		
Vaginal Birth	Y N		
Traumatic Birth	Y N	If yes, please describe:	_____

_____

_____

Length of labor: _____

Breast fed: Y N If yes, how long? _____ Formula: Y / N If yes, type: _____

Did your child satisfactorily meet all developmental milestones? Y / N
If no, please describe setbacks: _____

_____

PAST MEDICAL HISTORY Yes (Y), Past (P), No (N)

Has your child been immunized? Y / N If yes, please specify:

Immunization	Y or N	Date(s) Received
Polio	Y N	
Measles, Mumps, Rubella	Y N	
Diptheria	Y N	
Hepatitis B	Y N	
Pertussis	Y N	
Tetanus	Y N	
Chickenpox	Y N	
Influenza	Y N	
Herpes Zoster (Shingles)	Y N	
Tuberculosis	Y N	
Pneumonia	Y N	
Meningitis	Y N	
Other (specify):	Y N	

Has your child had any adverse reactions to immunizations? Y N
If yes, which one(s) and describe the adverse reaction: _____

_____

Hospitalizations: Y / N If yes, please list:

Date	Reason	Length of Stay
1.		
2.		
3.		

Surgeries: Y / N If yes, please list:

Date	Procedure	Complications
1.		
2.		
3.		

History of antibiotic use? Y P N If yes, what reason: _____

_____

Jaundice as baby	Y N	Colic	Y N
Cradle Cap	Y N	Anemia	Y N
Asthma	Y N	Eczema	Y N
Behavioral issues	Y N	Bedwetting	Y N
Early puberty	Y N	Excessive sweating	Y N
Picky eater	Y N	Frequent earaches	Y N
Irritable	Y N	Frequent sore throats	Y N
Frequent colds	Y N		

Normal hearing?	Y N	Never Tested	
Normal vision?	Y N	Never Tested	
Speech impediments?	Y N	Never Tested	If yes, describe: _____
Learning disabilities?	Y N	Never Tested	If yes, describe: _____

FAMILY HISTORY

Please indicate whether child or family member(s) has or had any of the following illnesses:

Family Member	**Autoimmune Disease** (specify)	**Cancer** (specify)	**Cardiovascular Disease** (specify)	**Diabetes**	**Mood Disorders** (specify)	**Neurological Disorders** (specify)	**Thyroid Disease**
Child	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N
Mother	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N
Father	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N
Sibling(s)	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N
Maternal Grandmother	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N
Maternal Grandfather	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N
Paternal Grandmother	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N
Paternal Grandfather	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N	Y P N

If death directly resulted from any of the illnesses listed above, please note family member(s) and age of death: _____

_____

_____

_____

_____

REVIEW OF SYSTEMS

General:

Weakness	Y P N	Chills	Y P N
Fatigue	Y P N	Night sweats	Y P N
Fever	Y P N		

Has your child had a weight gain or loss of 5 or more pounds within the past month? Y N
If yes, how many pounds gained or lost? _____

Has your child experienced any changes in appetite? Y N
If yes, describe the changes: _____
_____

Have you noticed any changes in your child's sleeping habits? Y N
If yes, describe the changes: _____
_____

Head:

Trauma	Y P N	Dizziness	Y P N
Headaches	Y P N	Lightheadedness	Y P N
Migraines	Y P N	Hair Loss	Y P N

Eyes:

Double vision	Y P N	Glaucoma	Y P N
Blurriness	Y P N	Photophobia	Y P N
Cataracts	Y P N	Vision changes	Y P N
Dryness	Y P N	Eye pain	Y P N

Date of last eye exam: _____

Ears:

Earache	Y P N	Ringing ears	Y P N
Discharge	Y P N	Vertigo	Y P N
Hearing loss	Y P N	Trauma to ear	Y P N

Nose:

Sinusitis	Y P N	Congestion	Y P N
Loss of smell	Y P N	Nosebleeds	Y P N
Discharge	Y P N	Nasal fracture	Y P N
Polyps	Y P N		

Mouth and Throat:

Oral lesions	Y P N	Difficulty swallowing	Y P N
Bleeding/sore gums	Y P N	Sore throat	Y P N
Cavities	Y P N	Teeth grinding	Y P N
Hoarseness	Y P N	Impaired speech	Y P N

Date of last dental exam: _____

Neck:

Trauma	Y	P	N	Swollen glands	Y	P	N
Pain or stiffness	Y	P	N	Lumps	Y	P	N
Goiter	Y	P	N				

Respiratory:

Asthma	Y	P	N	Bronchitis	Y	P	N
Chronic cough	Y	P	N	Pneumonia	Y	P	N
Wheezing	Y	P	N	Sputum	Y	P	N
Emphysema	Y	P	N	Blood in sputum	Y	P	N
Tuberculosis	Y	P	N	Shortness of breath	Y	P	N
Difficulty breathing	Y	P	N	with lying down	Y	P	N
Rapid breathing	Y	P	N	with exertion	Y	P	N
Painful breathing	Y	P	N	at night	Y	P	N

Cardiovascular:

High blood pressure	Y	P	N	Angina	Y	P	N
Murmur	Y	P	N	Chest pain	Y	P	N
Palpitations	Y	P	N	Dizziness	Y	P	N
Heart disease	Y	P	N	Swollen ankles/feet	Y	P	N
Leg pain (walking)	Y	P	N	Rheumatic fever	Y	P	N

Peripheral Vascular:

Coldness of hands/feet	Y	P	N	Varicose veins	Y	P	N
Numbness of hands/feet	Y	P	N	Spider veins	Y	P	N
Deep leg pain	Y	P	N	Thrombophlebitis	Y	P	N

Gastrointestinal:

Heartburn	Y	P	N	Belching	Y	P	N
Bloody stool	Y	P	N	Gas/bloating	Y	P	N
Gallbladder disease	Y	P	N	Hemorrhoids	Y	P	N
Liver disease	Y	P	N	Jaunice/yellow skin	Y	P	N
Vomiting	Y	P	N	Nausea	Y	P	N
Vomiting of blood	Y	P	N	Ulcers	Y	P	N
Rectal pain/itching	Y	P	N	Loose stool	Y	P	N

How often is your child having a bowel movement? _____

Do you notice the following in your child's stool?

Blood	Y	P	N
Mucous	Y	P	N
Undigested food	Y	P	N

Skin:

Acne	Y	P N	Boils	Y	P N
Itching	Y	P N	Rashes	Y	P N
Lesions	Y	P N	Hives	Y	P N
Bruising/color changes	Y	P N	Moles	Y	P N
Eczema	Y	P N	Dryness	Y	P N

Genitourinary:

Urge to urinate	Y	P N	Frequent urination	Y	P N
Blood in urine	Y	P N	Painful urination	Y	P N
Difficulty urinating	Y	P N	Kidney stones	Y	P N
Frequent infections	Y	P N	Incontinence	Y	P N
Urethral discharge	Y	P N			

Male Reproductive System:

Hernia	Y	P N	STDs	Y	P N
Testicular Pain	Y	P N	Testicular masses	Y	P N
Sexual/penile dysfunction	Y	P N	Prostate disease/pain	Y	P N
Discharges/sores	Y	P N	Genital warts	Y	P N
Infertility	Y	P N			

Female Reproductive System:

Age of first menses: _____ Normal puberty? Y N
Length of cycle: _____ Days of bleeding: _____ Regular cycle? Y P N
LMP: _____
Birth control? Y P N What type? _____
# of Pregnancies: _____ Births: _____ Miscarriages: _____ Abortions: _____
Pregnancy complications? Y N
If yes, please explain: _____
_____

Does your child have:

Painful menses	Y	P N	Painful intercourse	Y	P N
PMS	Y	P N	Heavy bleeding	Y	P N
Missed periods	Y	P N	Sexual dysfunction	Y	P N
Menopause symptoms	Y	P N	STDs	Y	P N
Pelvic pain	Y	P N	Vaginal itching/burning	Y	P N
Spotting	Y	P N	Vaginal discharge/sores	Y	P N
Genital warts	Y	P N			

Breast:

Nipple discharge	Y P N	Enlargement	Y P N
Breast pain	Y P N	Tenderness	Y P N
Lumps/mass	Y P N	Skin discoloration	Y P N
Self-breast exams	Y P N		

Musculoskeletal:

Joint pain/stiffness	Y P N	Broken bones	Y P N
Joint swelling	Y P N	Muscle cramps/spasms	Y P N
Arthritis	Y P N	Weakness	Y P N
Tenderness	Y P N	Muscle aches	Y P N

Neurological:

Numbness/tingling	Y P N	Seizures	Y P N
Fainting	Y P N	Paralysis	Y P N
Tremors	Y P N	Memory loss	Y P N
Loss of sensation	Y P N	Loss of coordination	Y P N

Endocrine:

Hot/cold intolerance	Y P N	Excessive thirst	Y P N
Excessive hunger	Y P N	Excessive urination	Y P N
Easy bleeding/bruising	Y P N	Anemia	Y P N
Low energy/fatigue	Y P N		

Mental/Emotional:

Anxiety/nervousness	Y P N	Excessive fears	Y P N
Depression	Y P N	Mood swings	Y P N
Easily angered	Y P N	Restlessness	Y P N
Suicidal thoughts	Y P N	Tension/Stress	Y P N

HEALTH HABITS:

Drink alcohol? Y P N If yes, how many drinks a day or week? _____
Smoke? Y P N If yes, how many cigarettes a day? _____
Recreational drug use? Y P N If yes, please list: _____
_____

Chemical or environmental exposures? Y P N
Please list type of exposure and any symptoms your child has experienced before, during or after exposure: _____
_____
_____

Does your child currently exercise? Y N
If so, how frequently and what activities? _____
_____
_____

How many hours does your child sleep? _____
Does s/he sleep through the night? Y N Does s/he have nightmares? Y N
Does s/he nap throughout the day? Y N
Insomnia? Y N Difficulty falling asleep or staying asleep? (circle one)
Does your child appear to be well-rested when s/he wakes? Y N

Describe your child's energy on a scale of 1-10 (1=low; 10=high): _____
Best time of day? _____ Worst time of day? _____

Does your child watch TV? Y N If yes, how many hours per day? _____
Does your child play video games? Y N If yes, how many hours per day? _____

Does your child have difficulty with school (i.e. academic performance)? Y N
If yes, please list all escape behavior(s): _____
_____
_____
Is your child stressed at home, school or social events? Y N
If yes, please list all coping mechanisms: _____
_____
_____

Please list your child's hobbies/interests: _____
_____
_____

Please list any concerns about your child that have not been addressed on this form.
_____
_____
_____