

Medicine Naturally

Integrative practice for children and women 922 S Cowley St, Ste 7, Spokane WA 99202 Ph: (509)262-8145 / www.medicine-naturally.com

PEDIATRIC INTAKE FORM (BIRTH TO 5 YEARS)

Patient's Name:			Date	Date:	
How did you hear about this clinic? Google Other					
Has any other family me	mber already been a patient at	this clinic?			
Name of doctor's office/	hospital/clinic where your chil	d's health record	ds are kept:		
What is the reason for to	day's visit:				
MEDICATIONS NOW PAST Aspirin Tylenol Antibiotics Ibuprofen	NOW PAST Decongestants Anti-histamine Other Allergies to medicines:				
MEDICAL HISTORY Chicken pox Skin rashes Eczema Asthma	Bronchitis Pneumonia Frequent colds Sinus Infection	Tonsillitis, approx no. of times: Ear infections, approx no. of times: Strep throat, approx no. of times: Other:			
Has your child ever had Electroencephalogram (l	any of the following? EEG):	WHEN	WHERE	RESULTS	
Psychological evaluations	::				
Hearing test:					
	alizations (please list):				
IMMUNIZATIONS Are immunizations up to Adverse reactions: Y/N If yes, what?		oring records at t	first visit)		



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FAMILY HISTORY					
Heart disease	Diabetes	Birth defects			
Hypertension	Arthritis	Tuberculosis	Tuberculosis		
Cancer	Allergies	Asthma			
		Other Significant:			
Mental or emotional illness	Osteoporosi	s			
PRENATAL HISTORY Previous pregnancies by natural mo	other, miscarriages, or	complications?			
Mother's age at child's birth:					
Mother's health during pregnancy:					
Bleeding	Nausea	Physical, emotional trau			
	Hypertension Cigarettes, alcohol, drug consumption				
Medications	Diabetes Thyroid problems				
BIRTH HISTORY					
	Length of labo	or:			
Term:Full Premature					
		Birth weight:			
Birth city & state:		<u> </u>			
Did you child have any of the follow	wing problems shortly	after birth?			
	7				
Jaundice	Seizures Cerebral palsy				
Colic		Birth defects			
Other:					
-4					
Child's sleep patterns (1 st year):					
Food intolerances:					
Breast fed: Y / N How long:					
Age began solids: Which					
Age began: Sitting	Crawling	_ Walking T	Talking		
SYMPTOMS					
Hives Burn	ning urine _	Bloody urine	Eczema		
Cries easily Blee	ding gums _	Heart murmur	Nervous		
Nose bleeds Vom	iting spells _	Sleep problems	Asthma		
Acne Anei	mia _	Night sweats	High fevers		
Jaundice Sens	itive to light _	Chronic rash	Stomach aches		
	ring loss	Easy bruising	Sore throats		
	ppetite _	Body/breath odor	Constipation		
	uent colds _	Bleeding tendency	Unusual fears		
_	t pains _	Excessive fatigue	Cough		
Dizzy spells Hair	loss _	Frequent urination	Allergies		



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DIET

Please describe your child's typical daily diet:	
Breakfast:	
Lunch:	
Dinner:	
Snacks:	
To drink:	