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 (6-15 years)

Name:_____Date: _____

How did you hear about this clinic? Google____ Other_____

Has any other family member already been a patient at this clinic?_____

## HEALTH HISTORY QUESTIONNAIRE

Birth city & state: _____ Birth weight:_____

What are your child's most important health problems? List as many as you can in order of importance:

1._____

2._____

3. _____

4. _____

5. _____

Does your child have a contagious disease at this time? Y N

If yes, what? _____

### PREVIOUS ILLNESSES

| | | | |
|---|---|---|---|
| Bronchitis | Y N | Asthma | Y N |
| Chicken pox | Y N | Eczema | Y N |
| Hay Fever | Y N | Sinus Infection | Y N |
| Tonsillitis | Y N | approx. number_____ | |
| Ear infections | Y N | approx. number_____ | |
| Other | Y N | list _____ | |

| Has your child had any of the following tests? | When | Where |
|---|---|---|

Electroencephalogram (EEG) _____

Psychological evaluation_____

Hearing tests_____

Speech/Language tests_____

### Hospitalizations/ Surgeries/ Injuries

What hospitalizations, surgeries or injuries has your child had?

_____

_____

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## Immunizations

Are immunizations up to date? Y / N (Please bring records at first visit)
Adverse reactions: Y / N
If yes, what? _____

## Allergies

Is your child hypersensitive or allergic to:

Any drugs?_____

Any foods? _____

Any environmentals?_____

Breast fed? _____ How long? _____ Formula? _____ Milk / Soy _____

## Typical Food Intake

Breakfast:_____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Please list **any** prescription medications, over the counter medications, vitamins or other supplements your child is taking:

1)_____ 5)_____

2)_____ 6)_____

3)_____ 7)_____

4)_____ 8)_____

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# REVIEW OF SYSTEMS

**Y** = a condition now **P** = significant problem in the past **N** = never had **S**= Sometimes a problem

**MENTAL/ EMOTIONAL**

| | | | | |
|---|---|---|---|---|
| Mood Swings | Y | P | N | S |
| Irritability | Y | P | N | S |
| Hyperactivity | Y | P | N | S |
| Introvert/extrovert | Y | P | N | S |
| Motion/car sickness | Y | P | N | S |
| Anxiety/nervousness | Y | P | N | S |
| Cries easily | Y | P | N | S |
| Unusual fears | Y | P | N | S |
| Sleep problems | Y | P | N | S |
| Nightmares | Y | P | N | S |

**ENDOCRINE**

| | | | | |
|---|---|---|---|---|
| Heat/cold intolerance | Y | P | N | S |
| Fatigue | Y | P | N | S |
| Excessive thirst | Y | P | N | S |
| Excessive hunger | Y | P | N | S |
| Low blood sugar | Y | P | N | S |
| High blood sugar | Y | P | N | S |

**SKIN**

| | | | | |
|---|---|---|---|---|
| Rashes | Y | P | N | S |
| Eczema, Hives | Y | P | N | S |
| Acne, Boils | Y | P | N | S |
| Itching | Y | P | N | S |

**HEAD**

| | | | | |
|---|---|---|---|---|
| Headaches | Y | P | N | S |
| Head Injury | Y | P | N | S |
| Dizzy spells | Y | P | N | S |
| High fevers | Y | P | N | S |

**EYES**

| | | | | |
|---|---|---|---|---|
| Glasses or contacts | Y | P | N | S |
| Tearing or dryness | Y | P | N | S |
| Eye pain/strain | Y | P | N | S |

**EARS**

| | | | | |
|---|---|---|---|---|
| Earaches | Y | P | N | S |
| Impaired hearing | Y | P | N | S |

**NOSE AND SINUSES**

| | | | | |
|---|---|---|---|---|
| Frequent colds | Y | P | N | S |
| Nose Bleeds | Y | P | N | S |
| Stuffiness | Y | P | N | S |
| Hay fever | Y | P | N | S |
| Sinus problems | Y | P | N | S |
| Loss of smell | Y | P | N | S |

**MOUTH AND THROAT**

| | | | | |
|---|---|---|---|---|
| Frequent sore throat | Y | P | N | S |
| Canker sores | Y | P | N | S |
| Breath odor | Y | P | N | S |

**RESPIRATORY**

| | | | | |
|---|---|---|---|---|
| Cough | Y | P | N | S |
| Wheezing | Y | P | N | S |
| Asthma | Y | P | N | S |
| Bronchitis | Y | P | N | S |

**CARDIOVASCULAR**

| | | | | |
|---|---|---|---|---|
| Heart disease | Y | P | N | S |
| Murmurs | Y | P | N | S |

**URINARY**

| | | | | |
|---|---|---|---|---|
| Frequent urination | Y | P | N | S |
| Bed wetting | Y | P | N | S |

**GASTROINTESTINAL**

| | | | | |
|---|---|---|---|---|
| Belching/passing gas | Y | P | N | S |
| Stomach aches | Y | P | N | S |
| Constipation | Y | P | N | S |
| Diarrhea | Y | P | N | S |
| Bowel Movements | How often _____ | | | |

**MUSCULOSKELETAL**

| | | | | |
|---|---|---|---|---|
| Joint pain/stiffness | Y | P | N | S |
| Muscle spasms/cramps | Y | P | N | S |
| Broken bones | Y | P | N | S |

**BLOOD/PERIPHERAL VASCULAR**

| | | | | |
|---|---|---|---|---|
| Anemia | Y | P | N | S |
| Easy bleeding/bruising | Y | P | N | S |

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Is there any information about your child's health that you would like to add?

What expectations do you have for your child from working with our clinic?