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Pediatric Intake Form

Name _____ Date of birth _____ Age _____ Sex M or F
Grade of School: _____
Address: _____
City: _____ State: _____ Zip: _____
Mother's Name and occupation: _____
Home Phone _____ Work Phone _____
Father's Name and occupation: _____
Home Phone _____ Work Phone _____
Parents are (circle): Married Separated Divorced Living Together Other
Emergency Contact _____
Regular Pediatrician name and city located in: _____
Reason for Office Visit: _____
Has child been seen by any other doctor(s) for this complaint? Yes No Past
Has child had any blood work done? If yes, please list what:

Please list any operations or hospitalizations and year occurred:

- 1.
- 2.
- 3.

Please list all medicines (from drugstore or prescription) child is on now:

- 1.
- 2.
- 3.
- 4.

Please list all supplements child is taking:

- 1.
- 2.
- 3.
- 4.

Any known Allergies to food, drugs, environment, animals: _____

I understand and agree that I am financially responsible for all charges and payment must be made at the time of visit unless other arrangements are made in advance. I understand and agree that I will pay a fee for the doctor's time if I fail to cancel or reschedule an appointment without 24 hours notice. I understand and agree that these charges will be billed to the credit card number I have given and authorized for the purposes of billing any and all missed appointments without 24 hour notification.

Patient's Signature _____ Date _____

Previous medical history

Yes indicates the child gets the problem regularly; **No** indicates the child never had the problem; **Past** indicates the child had the problem in the past but not recently. Please circle the correct one for your child.

Ear Infections? Yes No Past

If has had, how many total? _____

Colds? Yes No Past

If has had, how many total? _____

Strep throat? Yes No Past

If has had, how many total? _____

How many times has the child taken antibiotics: _____

What other medicines has the child taken? And how often?

1.

2.

3.

4.

Hearing tests Normal: Yes No Not Tested

Vision Tests Normal: Yes No Not Tested

Any speech impediments: Yes No Past

Learning impediments: Yes No Don't know

Vaccination History: **Yes**, has had; **No**, has not; **Some**, did not finish all shots

MMR: Yes No Some

DPT: Yes No Some

Hep B: Yes No Some

Hib: Yes No Some

Chickenpox: Yes No Some

Polio: Yes No Some

Other: _____

Any reactions to vaccinations? If so, please explain: _____

Family history

Allergies: Yes No

Obesity: Yes No

Cancer: Yes No

Tuberculosis: Yes No

Cardiovascular disease: Yes No

Mental Illness: Yes No

Diabetes mellitus: Yes No

Mother's Pregnancy history

Age at conception: _____

Did she have other children already? Yes No

Health During Pregnancy:

Smoking: Yes No

Diabetes: Yes No

Coffee: Yes No

Nausea/Vomiting: Yes No

Recreational drugs: Yes No

Emotional Stress: Yes No

Preeclampsia: Yes No

Length of Labor: _____

Vaginal birth: Yes No

Traumatic birth: Yes No

If the birth was difficult, please explain:

Health of baby at birth: _____

Mother's Pregnancy history

Child breastfed: Yes No For how long: _____
When put on formula: _____ What formula was used: _____
When was child put on solid food: _____
When did child Walk: _____ Talk: _____
Develop Teeth: _____

Health History of child

| | | | | | |
|-------------------------|-----|----|----------------|-----|----|
| Jaundice as baby: | Yes | No | Colic: | Yes | No |
| Cradle cap: | Yes | No | Anemia: | Yes | No |
| Eczema or psoriasis: | Yes | No | Asthma: | Yes | No |
| Diarrhea: | Yes | No | Warts: | Yes | No |
| Constipation: | Yes | No | Nightmares: | Yes | No |
| Finicky eating: | Yes | No | Bed-wetting: | Yes | No |
| Poor teeth: | Yes | No | Tantrums: | Yes | No |
| Chronic sniffles: | Yes | No | Disobedient: | Yes | No |
| Bad foot odor: | Yes | No | Fears/Phobia: | Yes | No |
| Very sweaty baby/child: | Yes | No | Diaper Rash: | Yes | No |
| Hyperactivity: | Yes | No | Early Puberty: | Yes | No |
| Growing pains: | Yes | No | Stomach aches: | Yes | No |

Any particular household stressors child has witnessed or gone through:

1. _____
2. _____
3. _____

Known Allergies to Food, Medicines, Pollens, Dander, etc.:

Typical Day's Diet:

Breakfast: _____
Snack: _____
Lunch: _____
Snack: _____
Supper: _____
Snack: _____

Toxin Exposure:

Has the child ever lived near a refinery or other highly polluted area? _____

Has the child ever lived in a house with lead paint? _____

Has the child ever lived in a house that had new paint, cabinets, carpeting installed and did that seem to affect their health at all? _____

Do you spray pesticides or herbicides around the house or use other toxic chemicals?

Does the child seem particularly sensitive to perfumes or other vapors? _____