Naturopathic Intake Form- Pediatric

PATIENT INFORMATION

Name: _____
Last First Middle

Address: _____
Street Apt. #

City: _____ State: _____ Zip: _____

Home Phone: _____ Birthdate: ___/___/___ Age: _____

Gender: M / F Email (parent)_____

GUARDIAN OR PARENT INFORMATION

Name: _____
First Middle Last

Address: _____
(if different from patient information) Street Apt. #

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Relationship to patient: _____ Occupation: _____

Marital Status: ☐ single ☐ partnered ☐ married ☐ divorced ☐ widowed ☐ separated

Social Security #: _____ Partner's Name: _____

Whom may we thank for referring you? _____
(Or how did you hear about us?)

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Phone Number: _____ Alt. Number: _____

Name: _____ Relationship: _____

Phone Number: _____ Alt. Number: _____

Name of Pediatrician: _____ Phone: _____

REASON(S) FOR SEEKING CARE

Please list your main health concern(s) *in priority order*:

Problem/Concern/Symptom:	Date of Onset
1st	
2nd	
3rd	
4th	
5th	
6th	
7th	

HEALTH HISTORY

Please check ☑ symptoms you currently have or have had:

- ☐ Acne
- ☐ Allergies
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Asthma
- ☐ Bed Wetting
- ☐ Birth Defects
- ☐ Bone Fractures
- ☐ Chicken Pox
- ☐ Colic
- ☐ Constipation
- ☐ Cough/Wheeze
- ☐ Cradle Cap
- ☐ Depression
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Dizzy Spells
- ☐ Eating Disorder
- ☐ Ear Infections
- ☐ Eczema
- ☐ Epilepsy/Seizure
- ☐ Fatigue
- ☐ Frequent Infections
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Fever
- ☐ Hyperactivity
- ☐ Insomnia
- ☐ Jaundice
- ☐ Learning Disorder
- ☐ Measles
- ☐ Moodiness
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Pneumonia
- ☐ Rubella
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stuffy Nose
- ☐ Thrush
- ☐ Thyroid Problems
- ☐ Tonsilitis
- ☐ Typhoid Fever
- ☐ Vomiting Spells
- ☐ Weight Gain/Loss
- ☐ Other: _____

IMMUNIZATIONS (Please list types, dates given, and any known adverse reactions)

CURRENT MEDICATIONS, VITAMINS, & OTHER SUPPLEMENTS: (Please include dosages)

HOSPITALIZATIONS, SURGERIES, OR SERIOUS INJURIES: (Please include dates)

ALLERGIES (drugs, food, or other substances):

PRENATAL/BIRTH/FEEDING HISTORY

Please list any health problems *mother* experienced during pregnancy with this child:

Term of pregnancy (circle one): Full Premature Late Birth Weight: _____

Any complications with delivery (circle one)? No Yes; _____

Place of Birth (circle one): Hospital Home Clinic Other: _____

Feeding (Please ☑ applicable):
Breast Fed: ☐ No ☐ Yes; How long? _____
Formula: ☐ No ☐ Yes; What type(s): _____ How long? _____
Age solid foods began: _____ What foods: _____
Food Intolerances: ☐ No ☐ Yes; (list foods) _____
Favorite foods: _____

24-hour Food/Drink Intake (please list yesterday): _____

SOCIAL HISTORY

Are parents (circle one): Married / Separated / Divorced / Other: _____

Mother's occupation: _____; Full-time / Part-time

Father's occupation: _____; Full-time / Part-time

Guardian: _____; Relationship: _____

Other's residing in home? ☐ No ☐ Yes; _____ Relationship: _____

Daycare? ☐ No ☐ Yes; Where: _____

Siblings? ☐ No ☐ Yes; (please list names, ages, and any health problems below:

_____

_____

_____

FAMILY HISTORY

☐ AIDS/HIV+	☐ Diabetes	☐ Osteoporosis
☐ Alcoholism	☐ Eczema	☐ Psoriasis
☐ Allergies/hay fever	☐ Gout	☐ Senility
☐ Arthritis	☐ Heart disease	☐ Seizures
☐ Asthma	☐ Hemophilia	☐ Skin problems
☐ Breast cancer	☐ High blood pressure	☐ Stroke
☐ Cervical cancer	☐ Kidney disease	☐ Suicide
☐ Ovarian cancer	☐ Loss of height	☐ Tuberculosis
☐ Prostate cancer	☐ Mental illness	☐ Thyroid problems
☐ Uterine cancer	☐ Migraines	☐ Ulcer
☐ Other cancer: _____	☐ Obesity	☐ Other: _____

OTHER INFORMATION

Is there anything else you would like the doctor to know about you/your child?

_____

_____

_____

_____

Consent of Financial Responsibility:

The ultimate responsibility of the fees is that of the undersigned/patient. **Patients are requested to provide 24-hour notice of cancellation. Without such notice, clients will be charged for the professional time at the regular hourly rate.** Your signature indicates your understanding and acknowledgement of the foregoing information. ***Please sign your name***:_____***Date***:_____

Please return this intake form to:

Natural Paths to Wellness
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Camp Hill, PA 17011
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email: admin@naturalpathstowellness.com