NAPA NATURAL MEDICINE

Pediatric Intake Form

Name _____ Age _____

Date of Birth _____ Gender _____

Height _____ Weight _____

Name of Parent or Guardian _____

Contact Information

Address _____

(Street) (City) (Zip Code)

Phone Number _____

(Home) (Mobile) (Work)

Email Address _____

What is the best way to reach you?

_____

How did you hear about us?

_____

Personal Health Information

(Please use additional pages or the back of this form as needed to complete health information)

What are your child's chief health concerns?

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

Is your child currently taking any prescription medication? (If yes please list name, amount, reason for use, length of use and name of prescriber)

1. _____
2. _____
3. _____

Is your child currently taking any vitamins, minerals, supplements, herbal or homeopathic medicines? (If yes please list name, amount, reason for use, length of use and name of prescriber)

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

Does your child have any allergies? (If yes, please list)

_____
_____
_____

Has your child ever been treated with any of the following medications? (Please circle)

Antidepressants/ Antibiotics/ Aspirin/ Asthma medications/ Corticosteroids/ Tylenol

Other _____

If your child has been treated with antibiotics – how many times and for what purpose?

Does your child receive regular checkups from a pediatrician? Yes No (Please circle one)

Has your child had any of the following health conditions in the past or do they currently have any of the following conditions?

Condition	Have it currently	Had it in the past (list when)	Condition	Have it currently	Had it in the past (list when)
Asthma			Ear infections		
Cancer			Eating disorder		
Chicken Pox			Measles		
Colds			Mumps		
Croup			Pertussis (Whooping Cough)		
Diabetes			Pneumonia		

Has your child been hospitalized or seriously injured in the past? (If yes, list event that occurred and dates)

Hospitalization or Injury	Date(s)	Hospitalization or Injury	Date(s)

Which of the following vaccines has your child received and when?

Vaccination	Date(s) Received	Vaccination	Date(s) Received
MMR (Measles, Mumps, Rubella)		Hepatitis	
DPT (Diphtheria, Pertussis, Tetanus)		Haemophilis Influenza	
Polio		HPV	
Influenza		Meningitis	
Other			

Did you child have an adverse reaction to any vaccinations? If yes, please list date, which vaccination precipitated reaction, and what reaction was?

_____

_____

Dietary Information

Was your child breastfed? (If yes, for how long. If not, please list formula used.)

_____

Does your child have any food allergies or intolerances not listed above? (If yes, please list)

_____

What does your child eat and drink on a typical day? (Include beverages)

Morning: _____

Afternoon: _____

Evening/Night: _____

Snacks: _____

Beverages: _____

Family Health Information

Has anyone in your family had any of the following health concerns?

Health Concern	Family Member	Health Concern	Family Member
Diabetes		High Blood Pressure	
Cancer		Alcoholism	
Heart Disease		Mental health concerns	

Does anyone else in your child's family (siblings, parents, or other family members) have any health concerns not listed above? (If yes, please list)

_____

Milestones

Please list when your child reached the following milestones:

Milestone	Age	Milestone	Age
Sitting		Crawling	
Walking		First word	
First foods			

Maternal Health History

How was the mother's health during pregnancy? (Please describe and list if there was gestational diabetes, hypertension, hypothyroidism, drug or alcohol use)

_____

_____

Did the mother take any pharmaceutical medication during the pregnancy? (If yes, please list)

_____

_____

What was the length of gestation of the child?

_____

How was your child delivered (in hospital, at home, midwife, MD, vaginally, C-section, etc)?

_____

_____

Were there any complications during your child's birth and were any interventions used/needed?

_____

_____

What was the height and weight of the child at birth?

_____

Environment and Activities

What activities does your child enjoy?

_____

_____

What type of schooling/educational experience is your child currently receiving?

_____

_____

Is your child exposed to smoke or any other environmental toxins that you are aware of?

_____

_____

Health Care Provider Information

_____	_____
(Name)	(Name)
_____	_____
(Address)	(Address)
_____	_____
(Phone) (Fax)	(Phone) (Fax)

Can we contact your other healthcare providers concerning your care? Yes No