PEDIATRIC INTAKE FORM
Birth-5 years

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Patient's Name:_____ Date:_____
Age:____ Date of Birth:____/____/_____ female male
Mother's name:_____ Father's name_____
Address:_____
City:_____ State:_____ Zip_____
Home Phone (_____)_____ Work Phone (_____)_____

How did you hear about this clinic:_____

Insurance
Health insurance: Company:_____
Policy/I.D. No.:_____ Group/code No.:_____
Name policy is in: _____

Name of Dr.'s Office/Hospital/Clinic where your child's health records are kept
_____
Reason for referral or presenting problems _____
_____

MEDICATIONS:	Now	Past		Now	Past
Aspirin	_____	_____	Antibiotics	_____	_____
Tylenol	_____	_____	Anti-histamine	_____	_____
Decongestant	_____	_____	Other	_____	_____
Ibuprofin	_____	_____	Allergies to medicines	_____	

MEDICAL HISTORY:
☐ Chicken pox ☐ Scarlet fever ☐ Measles ☐ Mumps ☐ Tonsillitis, approx. no. ____
☐ Pneumonia ☐ Rubella ☐ Ear infections, no. _____
☐ Rheumatic fever ☐ Frequent colds ☐ other (please list) _____

Has your child had any of the following tests? When Where Results
Electroencephalogram _____
Psychological evaluation _____
Hearing _____
Speech/Language _____
Injuries/Surgeries/Hospitalizations (please list): _____

IMMUNIZATIONS: ☐ Measles ☐ Polio ☐ MMR ☐ Smallpox ☐ Diphtheria
☐ Mumps ☐ DPT ☐ Tetanus ☐ Influenza Others (list) _____
Any adverse reactions? **Y N** What ? _____

FAMILY HISTORY: ☐ Heart disease ☐ Diabetes ☐ Birth defects ☐ Hypertension
☐ Arthritis ☐ Tuberculosis ☐ Cancer ☐ Allergies ☐ Mental illness

PRENATAL HISTORY: Previous pregnancies by natural mother, miscarriages, or complications?

_____

_____

Mother's age at child's birth? _____

Mother's health during pregnancy? ☐ Bleeding ☐ Nausea ☐ Diabetes
☐ Illnesses ☐ Medications ☐ Hypertension ☐ Thyroid problems
☐ Cigarettes, alcohol, drug consumption ☐ Physical or emotional trauma

BIRTH HISTORY:

Term: Full _____ Premature _____ Late _____ Weight at birth_____
Length of labor _____
Complications? _____

Did your child have any of the following problems shortly after birth?
☐ Birth defects ☐ Birth injuries ☐ Blue baby ☐ Rashes ☐ Colic
☐ Cerebral palsy ☐ Seizures ☐ Jaundice ☐ Fever

Other (explain) _____

Child's sleep patterns (first year) _____
Food intolerances (if any) _____
Feeding: Breast fed? _____ how long? _____ Formula? _____milk / soy _____
Age began solids _____ Which foods? _____
Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS (mark **Y** if current, **P** for past symptoms)

____ Hives	____ Burning of urine	____ Bloody urine	_____ Hair loss
____ Eczema	____ Frequent urination	____ Cries easily	_____ Excessive fatigue
____ Bleeding gums	____ Heart murmur	____ Nervous	_____ Unusual fears
____ Nose bleeds	____ Vomiting spells	____ Sleep problems	_____ Canker sores
____ Acne	____ Anemia	____ Night sweats	_____ Nightmares
____ High fevers	____ Stomach aches	____ Sensitive to light	_____ No appetite
____ Chronic rash	____ Jaundice	____ Body/breath odor	_____ Dizzy spells
____ Hearing loss	____ Easy bruising	____ Motion/car sickness	_____ Joint pains
____ Diarrhea	____ Flat feet	____ Bleeding tendency	_____ Frequent colds
____ Cough	____ Sore throats	____ Constipation	_____ Gas
____ Headaches	____ Wheezing		

DIET: Please describe your child's typical daily diet:

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
To Drink: _____

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

_____
_____
_____
_____

Thank you. We look forward to helping your child in any way we can.

Payment Details

☐ Cash ☐ Check ☐ Visa ☐ Mastercard

Name on Card:_____ Credit Card Number_____

Expiration Date:_____ 3 Digit Security Code:_____ (on back of card)

CONSENT FOR TREATMENT & FINANCIAL AGREEMENT:

By signing this, I hereby authorize the JUDY M. LEE N.D., C.H.M. to treat me using naturopathic medicines according to the principles of naturopathic practice. I understand JUDY M. LEE N.D., C.H.M. will make the best effort to treat but make no guarantee to cure me.

I certify that the above information is true. I understand that charges will be made and herby agree that I am financially responsible for any such charges.

Signed: _____ Dated: _____