PEDIATRIC INTAKE FORM
6-12 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 _____
_____

Does your child have a contagious disease at this time?.....Y N
If yes, what? _____

Previous Illnesses
☐ Rheumatic fever ☐ German measles ☐ Measles ☐ Tonsillitis: approx. number _____
☐ Ear infections: approx. number _____ ☐ Other: 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?
_____
_____

Immunizations
☐ Polio ☐ Pertussis ☐ Tetanus shot
☐ Diphtheria ☐ Measles/Mumps/Rubella ☐ Influenza
Any 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)_____ 4)_____
2)_____ 5)_____
3)_____ 6)_____

REVIEW OF SYSTEMS

Y = a condition now **P** = a condition in the past **N** = never had

MENTAL/ EMOTIONAL

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

ENDOCRINE

Heat/cold intolerance ..... Y P N	Fatigue ..... Y P N	High blood sugar . Y P N
Excessive thirst ..... Y P N	Excessive hunger ..... Y P N	Low blood sugar .. Y P N

SKIN

Rashes ..... Y P N	Eczema, Hives ..... Y P N	Acne, Boils ..... Y P N
Itching ..... Y P N		

HEAD

Headaches ..... Y P N	Head Injury ..... Y P N	Dizzy spells ..... Y P N
High fevers ..... Y P N		

EYES

Glasses or contacts ..... Y P N	Tearing or dryness ..... Y P N	Eye pain/strain .... Y P N

EARS

Earaches ..... Y P N	Impaired hearing ..... Y P N

NOSE AND SINUSES

Frequent colds ..... Y P N	Nose Bleeds ..... Y P N	Stuffiness ..... Y P N
Hayfever ..... Y P N	Sinus problems ..... Y P N	Loss of smell ..... Y P N

MOUTH AND THROAT

Frequent sore throat ..... Y P N Canker sores ..... Y P N Breath odor ..... Y P N

RESPIRATORY

Cough ..... Y P N Wheezing ..... Y P N Asthma ..... Y P N
Bronchitis ..... Y P N

CARDIOVASCULAR

Heart disease ..... Y P N Murmurs ..... Y P N

URINARY

Frequent urination ..... Y P N Bed wetting ..... Y P N

GASTROINTESTINAL

Belching/passing gas ..... Y P N Stomach aches ..... Y P N Constipation ..... Y P N
Diarrhea ..... Y P N Bowel Movements ..... Y P N How often:_____

MUSCULOSKELETAL

Joint pain/stiffness ..... Y P N Muscle spasms/cramps ... Y P N Broken bones ..... Y P N

BLOOD/PERIPHERAL VASCULAR

Anemia ..... Y P N Easy bleeding/bruising .... Y P N

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: _____