Confidential Patient Information
Pediatrics

Patient Contact Information

Name: _____ _____ _____/____/____
(Last) (First) (Sex) (Date of birth)

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___)_____Cell Phone (mom): (___)_____Cell Phone (dad): (___)_____

Email Address:_____

Mother's name and occupation:_____

Father's name and occupation:_____

Parents are: Married Separated Divorced Living Together Other:

Are there any custody arrangements we need to be aware of? Please state:

_____

_____

Sibling's name (s) and ages: _____

School:_____Grade:_____

Additional Patient Information

How did you first hear of us?
From another Patient The Internet/website The Newspaper Other

Name of person to thank for referring you to us:

Does your child also have a Pediatrician they see? Yes No

Name:_____

Were you referred by another physician: Yes No

If "Yes", could you provide us with as much information as possible for the Referring Physician?

Referring Physician's Name: _____

Address, City, State, Zip: _____

Telephone Number:_____

●Tucson Naturopathic Family Medicine●

Pediatric Intake Form

Patient Name: _____ **Date of Birth:** _____

List in order of importance why you are bringing your child in today:

1) _____
2) _____
3) _____
4) _____
5) _____

Has the child been seen by another physician for any of these complaints? Dr's name: _____

Family History

	Father	Mother	Siblings	Grandparents
Age if living:	_____	_____	_____	_____
Age when died:	_____	_____	_____	_____
Reason for death:	_____	_____	_____	_____
Cancer type:				
High Blood Pressure:	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N
TB:	Y N	Y N	Y N	Y N
Auto-Immune Disease:	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N

List All Surgeries, Hospitalizations, major illnesses, and accident including date occurred:

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Previous medical history:

YES (Y) indicates the child gets the problem **regularly; NO (N)** indicates the child **never** had the problem**; PAST (P)** indicates the child had the problem in the **past, but not recently. Please circle the correct one for your child.**

Ear Infections: Y N P **If has had, how many total**: _____

Colds: Y N P **If has had, how many total**: _____

Strep Throat: Y N P **If has had, how many total**: _____

How many times has the child taken antibiotics: _____

List other medicines your child is currently taken or has taken in the past:

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Does your child have any allergies to any medications or foods? What happens when he/she has an allergic reaction?

Please circle if your child has had any of the following diseases or immunizations. Indicate below if you choose not to vaccinate or vaccinate on a modified schedule:

Measles Mumps German Measles (Rubella) MMR vaccine
Chicken Pox Chicken Pox vaccine Diptheria Whooping Cough (Pertussis) DTaP vaccine
Hib vaccine Hepatits B vaccine Polio vaccine pneumonia vaccine (Prevnar) Rotavirus vaccine
Yearly flu vaccine meningiococcus vaccine HPV vaccine (Guarasil)
Not vaccinated Modified vaccination schedule

Any vaccination reactions?: _____

Mother's Pregnancy History

Age at conception: _____ **Did she have other children already**? Yes No

Smoking: Y N **Diabetes**: Y N **Coffee**: Y N **Nausea/Vomiting**: Y N

Recreational Drugs: Y N **Emotional Stress**: Y N

Preeclampsia: Y N **Length of Labor**: _____

Vaginal Birth: Y N **Traumatic Birth**: Y N

If the birth was difficult, please explain: _____

_____

Health of baby at birth: _____

Health History of Child

Child Breastfed: Y N **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:** _____

Hearing Tests Normal:	Yes	No	Not Tested
Vision Tests Normal:	Yes	No	Not Tested
Speech Impediments:	Yes	No	Past
Learning Impediments:	Yes	No	Past

Sleep

How many hours does your child generally sleep per night?

Does your child have difficulty falling asleep?

Does your child generally sleep through the night?

Does your child wake easily in the morning?

Is your child more of a morning person or a night "owl"?

Does your child experience any of the following night time behaviors:

Nightmares: Y N P	**Sleep walk**: Y N P	**Snore**: Y N P
Grind teeth: Y N P	**Sweating:** Y N P	**Bed Wetting:** Y N P
Restlessness: Y N P	**Talking:** Y N P	**Fears:** Y N P

What position does your child generally sleep in: (on back, stomach, legs tucked up, arms above head etc)

Does your child like to have covers on?

Does your child need a light on to sleep? **Music playing or white noise?**

Does your child like to have a fan blowing or a window open to sleep?

Any Particular household stressors child has witnessed or gone through:

1) _____ 2) _____

3) _____ 4) _____

Toxin Exposure

Has the child ever lived near a refinery, polluted area or in a home with leaded paint? If so, what sort of pollution was he/she exposed to? _____

Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health?

Does the child seem particularly sensitive to perfumes, gasoline or other vapors? _

Do you spray pesticides, herbicides or other chemicals around your home?

Do you use plastics?

Do you microwave food in plastic containers?

Do you use &/or reuse plastic water bottles?

Please describe a typical day's diet for your child:

Breakfast:

Lunch:

Dinner:

Snacks:

Drinks:

If your child could eat any foods no matter if it was a healthy choice or not, what food(s) would they choose as their favorites (i.e. cheese, milk, ice cream, mac n cheese, bread & butter etc).

Does your child have food aversions? (Foods they strongly dislike or always avoid?)

What temperature does your child prefer their drinks: warmed room temp cool chilled ice cold

Does your child tend to be: thirsty not thirsty

Tell me a little about your child's personality traits. How would your child appear to a complete stranger when they are feeling good & exhibiting their best traits?

How would they appear when they are not feeling so good (ill, tired, temper tantrum etc) & exhibiting their least desirable traits?

GENERAL

Weight Loss/Gain:	Y	N	P
Low Energy/Fatigue:	Y	N	P
Sleep Problems:	Y	N	P

SKIN

Jaundice-as a baby:	Y	N	P
Rashes:	Y	N	P
Hives:	Y	N	P
Eczema:	Y	N	P
Dryness:	Y	N	P
Lump(s):	Y	N	P
Itching:	Y	N	P
Warts/moles:	Y	N	P
Perspiration:	Y	N	P
Acne:	Y	N	P

HEAD

Headache/Migraine:	Y	N	P
Head Injury:	Y	N	P
Cradle cap-as a baby:	Y	N	P
Sweaty head:	Y	N	P

EYES

Glasses/contacts:	Y	N	P
Vision changes/loss:	Y	N	P
Dry/Watery/itchy:	Y	N	P
Pain:	Y	N	P
Eye Disease/injury:	Y	N	P
Styes:	Y	N	P
Discharge:	Y	N	P
Dark circles under Eyes:	Y	N	P

EARS

Hearing difficulty/loss:	Y	N	P
Pain:	Y	N	P
Wax buildup:	Y	N	P
Dryness/itching:	Y	N	P
Discharge:	Y	N	P
Chronic ear infections:	Y	N	P
Dizziness:	Y	N	P

NOSE

Seasonal Allergies:	Y	N	P
Frequent Colds:	Y	N	P
Congestion:	Y	N	P
Runny nose:	Y	N	P
Chronic sniffles:	Y	N	P
Nosebleeds:	Y	N	P

MOUTH/THROAT

Canker sores:	Y	N	P
Cold sores:	Y	N	P
Sore Throat:	Y	N	P
Poor teeth:	Y	N	P
Bleeding gums:	Y	N	P
Cavities:	Y	N	P
Hoarseness:	Y	N	P
Difficulty swallowing:	Y	N	P
Last dental exam:_____			

NECK

Stiffness/Tension/Pain:	Y	N	P
Swollen Glands:	Y	N	P

RESPIRATORY

Cough:	Y	N	P
Wheezing:	Y	N	P
Asthma:	Y	N	P
Painful breathing:	Y	N	P
Shortness of breath	Y	N	P
Bronchitis:	Y	N	P
Pneumonia:	Y	N	P

CARDIOVASCULAR

Heart Murmurs:	Y	N	P
Rheumatic Fever:	Y	N	P

BLOOD/LYMPH

History of anema:	Y	N	P
Type of anemia:_____			
Excessive Bruising:	Y	N	P
Bleeding Disorder:	Y	N	P
Blood Transfusion:	Y	N	P

URINARY

Urgency/Frequency:	Y	N	P
Incontinence:	Y	N	P
Pain w/ Urination:	Y	N	P
Frequent Infections:	Y	N	P
Nighttime Urination:	Y	N	P

GASTROINTESTINAL

Reflux:	Y	N	P
Colic- as a baby:	Y	N	P
Bowel Movement Frequency:			
_____			
Recent BM Change:	Y	N	P
Diarrhea:	Y	N	P
Constipation:	Y	N	P
Diaper rash:	Y	N	P
Nausea/Vomiting:	Y	N	P
Stomach aches:	Y	N	P
Change in Appetite:	Y	N	P

MUSCULOSKELETAL

Growing pains:	Y	N	P
Weakness:	Y	N	P
Stiffness:	Y	N	P
Leg Cramps:	Y	N	P
Tremors:	Y	N	P
Pain:	Y	N	P
Bad foot odor:	Y	N	P

NEUROLOGICAL

Fainting:	Y	N	P
Vertigo/Dizziness:	Y	N	P
Paralysis:	Y	N	P
Seizures:	Y	N	P

MENTAL/EMOTIONAL

Tantrums:	Y	N	P
Disobedience:	Y	N	P
Hyperactivity:	Y	N	P
Depression:	Y	N	P
Anger/irritability:	Y	N	P
Mood Swings:	Y	N	P
High-strung/tense:	Y	N	P
Anxiety:	Y	N	P
Fears/phobias:	Y	N	P

Homeopathic remedy consideration questions:

Please answer the questions as carefully, thoughtfully, and accurately as possible. Many of the questions may not seem directly related to your child's problem or main complaint, however, each one may help determine which homeopathic remedy is best suited for them. The information provided is not used in a judgmental way. It is purely to help the practitioner select the most appropriate remedy for your child. The more specific, characteristic and/or unusual are some of the most important. Being as honest & accurate are extremely important.
1 means the least, 5 means the most

Which weather conditions is your child most troubled by?

1 2 3 4 5 Cloudy 1 2 3 4 5 Clear 1 2 3 4 5 Wet 1 2 3 4 5 Dry

1 2 3 4 5 Storms 1 2 3 4 5 Wind 1 2 3 4 5 Hot Sun

1 2 3 4 5 Change of weather

Which season causes your child the most trouble or symptoms typically return?

Is your child ever worse being in the mountains? At the seashore?

Is your child generally chilly or warm?

Is your child generally sensitive to and/or troubled by:

1 2 3 4 5 Bright Light 1 2 3 4 5 Darkness

1 2 3 4 5 Open Air 1 2 3 4 5 Drafts

1 2 3 4 5 Stuffy Rooms 1 2 3 4 5 Tight Clothing

1 2 3 4 5 Noise 1 2 3 4 5 Odors

Answer as honestly as you can about your child's personality traits.

1 2 3 4 5 Hurried, impatient 1 2 3 4 5 Slow

1 2 3 4 5 Calm 1 2 3 4 5 Restlessness

1 2 3 4 5 Messy 1 2 3 4 5 Fastidious

1 2 3 4 5 Indolence (Lazy) 1 2 3 4 5 Always busy

1 2 3 4 5 Shyness/Timid/Bashful 1 2 3 4 5 Outgoing 1 2 3 4 5 Confidence

1 2 3 4 5 Anger 1 2 3 4 5 Obstinate (stubborn) 1 2 3 4 5 Impulsive

1 2 3 4 5 Irritability 1 2 3 4 5 Jealousy 1 2 3 4 5 fearful

1 2 3 4 5 Yielding 1 2 3 4 5 Mildness 1 2 3 4 5 weeps easily

1 2 3 4 5 Aversion of other people/company 1 2 3 4 5 Desire for company

1 2 3 4 5 Critical of self 1 2 3 4 5 Critical of others

1 2 3 4 5 child reproaches (find fault, scold, or blame) others 1 2 3 4 5 child reproaches self

1 2 3 4 5 Capriciousness (wants something & when offered child refuses)

How often does your child have the following behaviors?
1=never, 5=a lot

1 2 3 4 5 Abusive 1 2 3 4 5 Banging head 1 2 3 4 5 Biting 1 2 3 4 5 Breaks Things

1 2 3 4 5 Contrary (Opposite to what is logically expected) 1 2 3 4 5 Cursing 1 2 3 4 5 Disobedience

1 2 3 4 5 Insolent (insult, boldly rude) 1 2 3 4 5 Rage 1 2 3 4 5 Rudeness

1 2 3 4 5 Striking others 1 2 3 4 5 Striking self 1 2 3 4 5 Violence

How often does your child make mistakes with the following?

1 2 3 4 5 Numbers 1 2 3 4 5 Words (reading)

1 2 3 4 5 Words (speaking) 1 2 3 4 5 Words (writing)

Is your child forgetful of any of the following?

1 2 3 4 5 Dates 1 2 3 4 5 Names 1 2 3 4 5 Numbers

1 2 3 4 5 Of what someone else just said 1 2 3 4 5 Of what they just said 1 2 3 4 5 Of words

How sensitive is your child to any of the following?

1 2 3 4 5 Beauty 1 2 3 4 5 Criticism 1 2 3 4 5 Cruel Stories

1 2 3 4 5 Frightening things 1 2 3 4 5 Being made fun of 1 2 3 4 5 Music

1 2 3 4 5 Reprimand 1 2 3 4 5 Rudeness 1 2 3 4 5 The suffering of others

How afraid is your child of the following?
1 = not at all 5= very afraid.

1 2 3 4 5 Animals 1 2 3 4 5 Being alone 1 2 3 4 5 Death

1 2 3 4 5 Relative's Death 1 2 3 4 5 Impending Disease 1 2 3 4 5 Downward Motion

1 2 3 4 5 Evil 1 2 3 4 5 Failure 1 2 3 4 5 Falling

1 2 3 4 5 Ghosts 1 2 3 4 5 Heights 1 2 3 4 5 Misfortune (bad luck)

1 2 3 4 5 Of a Crowd 1 2 3 4 5 People 1 2 3 4 5 Robbers/Intruders

1 2 3 4 5 Snakes 1 2 3 4 5 Spiders 1 2 3 4 5 Strangers

1 2 3 4 5 That something will happen 1 2 3 4 5 Darkness 1 2 3 4 5 Thunderstorms

1 2 3 4 5 Water 1 2 3 4 5 Wind