



• Tucson Naturopathic Family Medicine •

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: _____



Adolescent Intake Form

Patient Name: _____ Date of Birth: _____

List in order of importance why you are coming in today:

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

Has your adolescent ever had blood work done and with what physician: _____

List All Surgeries, Hospitalizations, Injuries & Major illnesses, including date occurred:

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

Past Medical History

Are there any allergies to any medications or foods? What is the reaction?

Current Prescription Medications:

	Drug name	Dosage	Taking since	Taking For:
1.	_____			
2.	_____			
3.	_____			
4.	_____			
5.	_____			
6.	_____			

Natural supplements: (vitamins, minerals, herbs, homeopathics etc.)

	Supplement name	Dosage	Taking since	Taking For:
1.	_____			
2.	_____			
3.	_____			
4.	_____			
5.	_____			
6.	_____			

Family History

	Father	Father's Parents		Mother	Mother's Parents		Siblings
		GF	GM		GF	GM	
Age (if living):							
Age (if deceased):							
Reason for death:							
Cancer type:							
High Blood Pressure:							
Heart Attack:							
Heart Disease:							
Stroke:							
Asthma/Allergies:							
Mental Illness: type?							
Auto-Immune Disease:							
Diabetes Mellitus:							
Osteoporosis:							

Diet/Lifestyle

List the foods you typically consume for breakfast, lunch, dinner & snacks.

Breakfast	Lunch	Dinner	snacks

How many times each week do you eat desserts (e.g. cookies, cakes, ice cream, candy etc.)?

Do you drink coffee or tea? Y N If yes, how many cups each day? _____

Do you use artificial sweeteners? Y N If yes, what type? _____

Do you drink soda? Y N If yes, how many times each week? _____

Do you drink fruit juice? Y N If yes, how many times each week? _____

How much water do you drink per day: _____

If you could eat any food(s) frequently no matter if it was a healthy choice or not, what food(s) would you choose as you favorites or whatever you crave?

Do you have food aversions? (Foods you strongly dislike or always avoid?)

What temperature do you prefer your drinks? warmed room temp cool chilled ice cold

Do you tend to be: thirsty or not thirsty

Indicate Yes (Y=current), No (N=never) or Past (P=anytime in the past) regarding use of the following:

Alcohol: Y N P How often & how much: _____ Any Alcohol Addiction: Y N P Any Alcohol Treatment: Y N P

Smoking: Y N P Recreational Drugs: Y N P Drugs used: _____ Any Drug Treatment: Y N P

Sleep

How many hours per night? _____ Difficulty falling asleep? _____ Difficulty Staying asleep? _____

Nightmares: Yes No Past Wake Refreshed: Yes No Must nap during the day: Yes No Past

Sleep walk: Yes No Past Grind teeth: Yes No Past Snore: Yes No Past Perspiration: Yes No Past

Circle what you prefer. Do you sleep: Without Covers Partly Covered Fully Covered (Not including Head)

Fully Covered (Including Head) With Arms or Legs Out of the Covers Without Clothing

With a Fan or Air Blowing on You With the Window open

Exercise

How often do you exercise? _____ What type of exercise? _____

For how long each time? _____

Weight concern? Y N

Present Weight: _____ Height: _____ Weight one year ago: _____ Ideal Weight: _____

Maximum weight and when: _____

Good Energy? Y N

On a scale of 1 to 10 with 1 (lowest) & 10 (highest), what is your average daily energy level?
1 2 3 4 5 6 7 8 9 10

Fatigue? Y N If yes, when is your fatigue the worst? Morning Afternoon Evening

If you have fatigue, can you still do what you need to do during the day?

What type of school do you attend? Homeschool Charter/Online Public Private

Do you enjoy school? Y N Highest level of education completed: _____

Hobbies: _____

Active spiritual practice: Y N

Sexually Active: Y N

What types of stressors have you dealt with in the past and present? _____

How do you best deal with those stressors? _____

Circle any that apply: History of sexual, mental/emotional, or physical abuse: Yes No

If so, at what age and by whom: _____

What is your greatest health concern: _____

How does it limit you the most: _____

Review of Systems

Please circle any of the conditions or symptoms below if you have experienced them significantly within the last 6 months.

GENERAL

Fatigue Weight change Fever Chills Weakness
Night sweats Insomnia Heat/Cold Intolerance
Excessive Hunger/Thirst

SKIN

Itching Rashes Hair/Nail changes Excessive Perspiration

HEAD

Headache Trauma Dizziness

EYES

Vision changes Pain Eye Injury Discharge Blurry Vision
Double Vision Eye Disease Dark Circles Under Eyes
Last Eye Exam: _____

EARS

Hearing Changes Tinnitus (ringing) Pain Discharge
Itching Infections

NOSE

Bleeding Discharge Sinus infections Allergies
Congestion Decrease in Smell

MOUTH/THROAT

Sores Gums bleeding Hoarseness Loss of Taste
Pain/Difficulty Swallowing Sore Throat
Last Dental Exam: _____

LUNGS/BREATHING

Wheezing Cough Coughing blood Pain
Shortness of breath

CARDIOVASCULAR

High/Low Blood Pressure Irregular Heart Beats Palpitations
Chest Pain Swollen ankles Calf pain

BLOOD-LYMPHATIC SYSTEM

Anemia Bleeding disorder Excessive Bruising
Swollen lymph nodes

URINARY/URINATION

Pain Waking at night Incontinence Infections

Frequency Urgency Blood In Urine Kidney Stones

GASTROINTESTINAL

Heartburn Indigestion Reflux Excessive Gas Belching
Bloating Appetite Change Nausea Vomiting

Constipation Diarrhea Hemorrhoids Blood in stool

Pain Change in Bowel Movements

Frequency of Bowel Movements: _____

MUSCLES, JOINTS & BONES

Trauma Pain Arthritis Weakness Leg Cramps

NEUROLOGIC

Fainting Seizures Numbness Tingling Speech problems

Paralysis Tremor Sciatica Carpal Tunnel

MENTAL/EMOTIONAL

Anxiety Depression Fear/Panic Mood Swings Tension

Phobias Memory loss Anger/Irritability Suicidal Ideations

SEXUALLY TRANSMITTED DISEASES

Syphilis Gonorrhea Chlamydia Herpes HPV HIV

Hep B or C Sores / discharge Pelvic pain

BREASTS

Masses Pain/Tenderness Discharge Dry Skin on Breast

FEMALES

Heavy bleeding Pain/Cramping Irregular cycle Spotting

PMS Vaginal pain Vaginal Infections

Date of last period: _____

Days between periods: _____

Days periods last _____ Heavy flow days: _____

Times Pregnant: _____ How Many Births: _____

Miscarriages: _____ Abortions _____

PAP & Pelvic exam? Yes No Date: _____

MALE

Testicular pain Swelling Masses Discharge

Please answer the questions as carefully, thoughtfully, and accurately as possible. Many of the questions may not seem directly related to your main complaint, however, each one may help determine which homeopathic remedy is best suited for you. The information provided is not used in a judgmental way. It is purely to help the practitioner select the most appropriate remedy for you. The more specific, characteristic and/or unusual symptoms are some of the most important. Being as honest & accurate are extremely important. 1 means the least, 5 means the most or 1 means never, 5 means a lot

Which weather conditions are you 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 you the most trouble or symptoms typically return?

Are your symptoms ever worse being in the mountains?

At the seashore?

Are you generally chilly or warm?

Are you generally more sensitive to cold or heat?

How often do you perspire? (Never) 1 2 3 4 5 (All of the time) **What area of your body sweats the most?** _____

What are your feelings toward disease? Optimistic Doubtful of recovery Fearful Anxious Uninterested

What time(s) of day are you generally worst (mood, energy, symptoms, etc.)

What time(s) are you best?

Are you 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

Rate these foods on how much you like or dislike them?

1 2 3 4 5 bacon 1 2 3 4 5 butter alone 1 2 3 4 5 cheese 1 2 3 4 5 chocolate 1 2 3 4 5 coffee
 1 2 3 4 5 eggs 1 2 3 4 5 fat (meat, chicken, pork etc) 1 2 3 4 5 fish 1 2 3 4 5 fruit
 1 2 3 4 5 ice 1 2 3 4 5 ice cream 1 2 3 4 5 indigestible things (chalk, clay, paper)
 1 2 3 4 5 lemonade 1 2 3 4 5 meat 1 2 3 4 5 milk 1 2 3 4 5 pickles 1 2 3 4 5 pasta,breads etc

What type(s) of flavors do you usually like best? Sweet sour salty bitter spicy

Do you experience any specific taste in your mouth (i.e. sweet, bitter, foul, metallic, etc)

Answer as honestly as you can about these 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 Neat 1 2 3 4 5 Indolence (Lazy) 1 2 3 4 5 Always busy
 1 2 3 4 5 Shy/Timid/Bashful 1 2 3 4 5 Outgoing 1 2 3 4 5 Confident 1 2 3 4 5 fearful
 1 2 3 4 5 Anger 1 2 3 4 5 Irritability 1 2 3 4 5 Stubborn 1 2 3 4 5 Impulsive
 1 2 3 4 5 Jealousy 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 Talkative
 1 2 3 4 5 Critical of self 1 2 3 4 5 Critical of others 1 2 3 4 5 Irresolution (Not being able to decide or stick to a decision)
 1 2 3 4 5 Reproaches (find fault, scold, or blame) others 1 2 3 4 5 Reproaches self
 1 2 3 4 5 Capriciousness (wants something & when offered you refuse) 1 2 3 4 5 Selfishness

Does it make you feel better or worse when someone consoles you?

How much do you worry about the following?

1 2 3 4 5 Financial Security 1 2 3 4 5 Health 1 2 3 4 5 Mental Functioning 1 2 3 4 5 Morals/Past Indiscretions
1 2 3 4 5 Others' (family and close friends) well being 1 2 3 4 5 Religion 1 2 3 4 5 Social Life
1 2 3 4 5 The Future 1 2 3 4 5 School Work

How often do you have the following behaviors?

1 2 3 4 5 Abusive 1 2 3 4 5 Breaks Things 1 2 3 4 5 Cursing
1 2 3 4 5 Contrary (Opposite to what is logically expected) 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 Throwing things 1 2 3 4 5 Violence

How often do you 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)

Are you 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 you just said 1 2 3 4 5 Of words

How sensitive are you 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 are you of the following?

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

Which best describes your feelings toward any Significant past emotionally traumatic events:

Resolved Grief Dwells on Past Inconsolable Remorse Guilt

Feeling towards people close to you:

Loving Affectionate Indifferent Resentment Hatred

Feeling toward life:

Love life Indifferent Bored Weary of life Loathing of life Desires death Suicidal thoughts Suicidal disposition