NATURAL HEALING FAMILY MEDICINE
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NATUROPATHIC PHYSICIAN

Pediatric/Adolescent
Health History Intake Form

Last Name:_____First Name:_____Middle Name:_____

Date of Birth:_____Age:_____Sex:_____Today's Date:_____

PRENATAL/BIRTH HISTORY

A. Mother's Pregnancy: □Normal
□Complications:_____
B. Gestation:_____weeks
C. Birth Location: □Hospital □Birthing Center □Home
□Other_____
D. Delivery: □Vaginal □C-Section…..Any Complications: □No
□Yes_____
E. Birth Weight:_____lbs_____oz…..Length:_____inches

PRESENT HEALTH CONCERNS: Please list most important health concerns in their order of significance

1._____

2._____

3._____

4._____

PAST MEDICAL HISTORY

MEDICATIONS: Please list prescription medications +/or over the counter medications that you are currently taking, with dosages

1._____ 2._____ 3. _____

4. _____ 5. _____ 6. _____

SUPPLEMENTS: Please list vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages

1._____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

ALLERGIES: Please include mild to severe or life-threatening allergies and reaction (symptoms)

1. Medications:_____

2. Environment:_____

3. Food:_____

PAST MEDICAL HISTORY

CHILDHOOD ILLNESSES: (Circle and indicate age of illness OR mark C for current as it applies to your child)

Acne:	No	Yes/Age_____	Ear Infections:	No	Yes/How often:_____
ADD:	No	Yes/Age_____	Eating Disorders:	No	Yes/Age and type:_____
ADHD:	No	Yes/Age_____	Eczema:	No	Yes/Age:_____
Alcohol use:	No	Yes/How often:_____	Head lice:	No	Yes/Age:_____
Allergies:	No	Yes/Age_____	Molluscum contagiosum:	No	Yes/Age:_____
Asthma:	No	Yes/Age_____	Mononucleosis:	No	Yes/Age:_____
Bedwetting:	No	Yes/Age_____	Obesity/Overweight:	No	Yes/Age:_____
Behavior problems:	No	Yes/Age_____	Pink eye:	No	Yes/Age:_____
Bronchitis	No	Yes/Age_____	Pneumonia:	No	Yes/Age:_____
Colic:	No	Yes/Age_____	Colds:	No	Yes/How often:_____
Constipation:	No	Yes/How often:_____	Sinus Infection:	No	Yes/How often:_____
Cough:	No	Yes/How often:_____	Thrush:	No	Yes/Age:_____
Croup:	No	Yes/Age_____	Vomiting:	No	Yes/Age:_____
Depression	No	Yes/Age_____	Whooping cough:	No	Yes/Age:_____
Diaper rash:	No	Yes/How often:_____	Other:		
Age:_____Illness:_____					
Diarrhea:	No	Yes/How often:_____	Other:		
Age:_____Illness:_____					

IMMUNIZATIONS: (Please place an **X** in either the Yes or No box next to each vaccination that you have been vaccinated against. If Yes, please indicate whether there were any reactions and describe in detail)

	No	Yes	Reaction Description
Hepatitis B			
Diphtheria, Tetanus, Pertussis			
Haemophilus Influenza Type B			
Inactivated Polio			
Measles, Mumps, Rubella			
Varicella (Chickenpox)			
Pneumococcal			
Influenza			
Rotavirus			
Human Papilloma Virus (HPV)			

SERIOUS INJURIES AND/OR ACCIDENTS: (Indicate type, date and treatment used)

Type	Date	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

HOSPITALIZATIONS/SURGERIES: (Indicate reason and date)

Reason for Hospitalization	Date
_____	_____
_____	_____
_____	_____

PAST MEDICAL HISTORY-Con't

LABS AND EXAM HISTORY: Please indicate date and results.

Date of last well child check:_____ Results: □ Normal □ Other
_____

Date of last blood work:_____ Results: □ Normal □ Other
_____

Date of last urine test:_____ Results: □ Normal □ Other
_____

Adolescents:

Date of last PAP and pelvic exam:_____ Results: □ Normal □ Other
_____

FAMILY HISTORY: Please place a "C" for current or "P" for past in the box next to each condition as it applies to you or your family members.

	Self	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcoholism									
Allergies									
Anemia									
Arthritis									
Asthma									
Cancer									
Depression									
Diabetes									
Drug Addiction									
Eczema									
Epilepsy									
Headaches									
Heart Disease									
Hepatitis									
High Blood Pressure									
Kidney Disease									
Mental Illness									
Stroke									
Tuberculosis									

SOCIAL HISTORY

Have you or your parents ever consulted with a Naturopathic Physician before? □ Yes □ No

Parent's Marital Status: □ Single □ Married □ Divorced □ Separated/Not Divorced □ Widowed □ Domestic Partnership

Siblings (Indicate names and ages)

1._____ 7._____
2._____
3._____ 8._____
4._____
5._____ 9._____
6._____

Mother's Occupation:_____Father's Occupation:_____

Guardian's Occupation:_____

Daycare Location:_____Days/Hours per week:_____

SOCIAL HISTORY-Con't

BIRTH CONTROL:
Adolescents:
What form of contraception/birth control are you using (Check all that apply).
□ Abstinence □ Withdrawal □ Fertility Awareness Method □ The Sponge □ Spermicide □ Condom □ Diaphragm □ Cervical Cap □ IUD □ The Pill □ The Shot (Depo-Provera) □ The Ring □ Implants □ The Patch □ Vasectomy □ None

TRAVEL HISTORY: Identify any domestic or foreign travel and indicate year of travel:
Place:_____ Year:_____
Place:_____Year:_____

PERSONAL HABITS: Identify any substances you have used and circle whether in the past (P) or are currently using (C)
Adolescents:
Which of the following substances do you use and identify frequency (Ex. 2x/d, 1x/mo, 1x/yr)?
□ Tobacco: P C Freq:_____ □Recreational Drugs: P C Identify type/Freq:_____
□ Alcohol: P C Freq:_____ □Other: P C Specify/Freq:_____
□ Coffee: P C Freq:_____

EXERCISE:
Toddlers/Adolescents:
Do you exercise regularly? □ Yes □ No
If you checked yes to exercising regularly, answer the following questions: What type/activity?_____
How long?_____
How Often?_____

SLEEP:
How many hours of sleep do you get at night on average?_____
Toddlers/Adolescents:
How often do you wake and for what reasons?_____
Do you have any trouble falling asleep? □ No □ Yes/Why?_____
Do you have trouble waking up? □ No □ Yes/Why_____
Do you wake rested? □ Yes □ No/Why
_____

ENERGY AND STRESS:
Adolescents:
How would you rate your energy on a scale of 1 – 10 with 10 being the most energy?_____
How would you rate your stress on a scale of 1 – 10 with 10 being the most stress?_____
How do you cope with stress?_____

NUTRITIONAL HISTORY
Infant/Toddlers:
Type: □Nursing □Formula/Specify_____ □Both Duration: □<15 min □15-30 min □30-45 min □45-60 min
Frequency: □Every hour □Every other hour □Every 3rd hour Amount per feeding: □<1oz □1-2oz □2-3oz □3-4oz □>4oz □Every 4th hour □Every 5th hour □Other_____

NUTRIONAL HISTORY Cont.
Adolescents:
What is a typical breakfast?_____
What is a typical lunch?_____
What is a typical dinner?_____
What are typical snacks?_____
How many glasses of water do you drink each day on average?_____
Do you have any special dietary restrictions?_____