

Well-Natured Naturopathic Care, LLC

21332 Provincial Blvd.
Katy, TX 77450
phone: 281-650-0405; fax 978-359-0405

Pediatric Intake Form

Today's Date: _____

Patient's Name: _____ Age: _____
(Last) (First) (MI)

Date of Birth: _____ Sex: M____ F____ Blood Type: _____ (+ or -)

Parent/Guardian Contact Information

Name(s): _____

Address: _____

_____ (Street) (City) (State) (Zip)

Home Phone: _____ Business Phone: _____

Cell Phone: _____ E-mail: _____

How do you prefer to be contacted? Home Work Cell E-mail

May we leave a message? Home Work Cell E-mail

Emergency contact: _____

_____ (Name, relationship, day & evening telephone)

How did you hear about our clinic?

Healthcare Providers

Pediatrician: _____

_____ (Name/Phone/Address)

Date of Last Physical Exam: _____
(Month & Year)

Primary health concerns:

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

Current medications *(Please list name of drug and length of time used. Please include any over-the-counter medications and nutritional or botanical supplements)*

Allergies/Adverse Reactions to Medications & Substances

Please describe any adverse or allergic reactions that you have had to any of the following: prescription drugs, over-the-counter-medications, recreational drugs, vaccinations, herbs, vitamins, minerals or homeopathics

Name of substance	Describe the reaction

Environmental/Food Allergies & Sensitivities (food, pollen, mold, animals, chemicals)

Name of allergen	Describe the reaction

Family History (Please check those that apply)

- allergies alcoholism asthma autoimmune disease
 bleeding disorder cancer diabetes epilepsy
 heart disease learning disability tuberculosis mental illness
 arthritis hypertension

Immunizations

- mmr dpt chicken pox smallpox
 measles diphtheria h. influenzae hepatitis b
 mumps tetanus rubella polio

others: _____

Did your child have any adverse reactions to any of the above vaccines? Yes No

Prenatal History

Maternal age at child's birth: _____

Mother's health during pregnancy:

- bleeding nausea physical or emotional trauma
 illnesses hypertension cigarettes, alcohol, or drug consumption
 diabetes thyroid problems medications

Birth History

Term: full/premature/late

Length of Labor: _____

Complications? _____

Did your child have any of the following after birth?

- Rashes Jaundice Blue baby Colic Birth injuries
 Cerebral palsy Seizures Fever Difficulty feeding

Other: _____

Was the child breast fed? Yes No

Was the child fed formula? Yes No If yes, what type: milk, soy, other _____

Age of introduction to solid foods: _____

Age began: sitting _____ crawling _____ walking _____ talking _____

Medical History (Please check any of the following that your child may have experienced. Please mark (C) for current and (P) for past)

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> measles | <input type="checkbox"/> rubella | <input type="checkbox"/> strep throat |
| <input type="checkbox"/> scarlet fever | <input type="checkbox"/> mumps | <input type="checkbox"/> tonsillitis | <input type="checkbox"/> freq. colds |
| <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> headaches | <input type="checkbox"/> cough/wheezing | <input type="checkbox"/> allergies |
| <input type="checkbox"/> bed wetting | <input type="checkbox"/> anxiety | <input type="checkbox"/> skin disorders/eczema | <input type="checkbox"/> nightmares |
| <input type="checkbox"/> constipation | <input type="checkbox"/> diarrhea | <input type="checkbox"/> indigestion/gas | <input type="checkbox"/> wheezing |
| <input type="checkbox"/> insomnia | <input type="checkbox"/> asthma | <input type="checkbox"/> behavioral disorder | <input type="checkbox"/> vomiting |
| <input type="checkbox"/> hives | <input type="checkbox"/> bloody urine | <input type="checkbox"/> bleeding gums | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> pneumonia | <input type="checkbox"/> ear infections | <input type="checkbox"/> burning/difficult urination | <input type="checkbox"/> anemia |
| <input type="checkbox"/> heart murmur | <input type="checkbox"/> hearing loss | <input type="checkbox"/> appetite loss | <input type="checkbox"/> joint pain |
| <input type="checkbox"/> stomach aches | <input type="checkbox"/> sleep problems | <input type="checkbox"/> night sweats | <input type="checkbox"/> rashes |
| | | | |
| <input type="checkbox"/> hair loss | <input type="checkbox"/> high fevers | <input type="checkbox"/> easy bruising | <input type="checkbox"/> body odor |
| <input type="checkbox"/> bad breath | <input type="checkbox"/> unusual fears | <input type="checkbox"/> bleeding tendencies | <input type="checkbox"/> dizzy spells |
| <input type="checkbox"/> sore throat | <input type="checkbox"/> cough | <input type="checkbox"/> nasal congestions | <input type="checkbox"/> constipation |
| <input type="checkbox"/> excessive fatigue | <input type="checkbox"/> frequent urination | | |
| <input type="checkbox"/> other | | | |
-

Diet (Please describe your child's typical diet)

Breakfast:

Lunch:

Dinner:

Snacks:

Drinks:

Food aversions:

Favorite foods:
