PATIENT INTAKE FORM

This is a confidential report. Your honest evaluation is both pertinent and necessary to better enable the doctor to accurately assess the health of your child and effectively work with you to improve your child's general well-being.

Child's Name:_____ Birth date:_____ Age:_____ Height:_____ Weight:_____

Mother's Name:_____ Father's Name:_____

Address:_____ City:_____ ST:_____ Zip:_____

Home Phone: ( )_____ Work Phone: ( )_____ Best time to call: _____

Current Physician:_____ Referred by: _____

Main problem: _____

_____

I. CURRENT INFORMATION

Is the child currently taking any medications? ○ Yes ○ No If so, list medications: _____

_____

II. FAMILY MEDICAL HISTORY

If any blood relatives to the patient have or have had any of the following illnesses, please check accordingly: M (Mother); F (Father); S (Sibling); PGM (Paternal Grandmother); PGF (Paternal Grandfather); MGM (Maternal Grandmother); MGF (Maternal Grandfather)

M	F	S	PGM	PGF	MGM	MGF	
○	○	○	○	○	○	○	Allergy, asthma or eczema
○	○	○	○	○	○	○	Cancer
○	○	○	○	○	○	○	Diabetes or low blood sugar
○	○	○	○	○	○	○	Heart trouble
○	○	○	○	○	○	○	High blood pressure/Stroke
○	○	○	○	○	○	○	Kidney disease
○	○	○	○	○	○	○	Liver disease
○	○	○	○	○	○	○	Tuberculosis
○	○	○	○	○	○	○	Thyroid problems
○	○	○	○	○	○	○	Mental illness/Nervous disorders
○	○	○	○	○	○	○	Alcoholism
○	○	○	○	○	○	○	Other: _____

_____

III. PREGNANCY

Please check any area that applied to the patient's mother during her pregnancy:

- ○ Recreational drugs
- ○ Smoking
- ○ Alcohol
- ○ Caffeine: cola, coffee, tea, chocolate, etc.
- ○ Vitamins/minerals
- ○ Back pain
- ○ Excessive decrease in weight
- ○ Excessive increase in weight
- ○ Prenatal care
- ○ Attitude-Happy (majority of time)
- ○ Attitude-Depressed
- ○ Complications
- ○ Medications
- ○ Any diagnosed illnesses
- ○ Hospitalization
- ○ Immunization
- ○ Allergic reactions
- ○ Mental trauma
- ○ Physical injury
- ○ Toxic exposure
- ○ Bleeding
- ○ Carried to full term
- ○ Premature contractions

IV. LABOR AND DELIVERY

- ○ Home birth
- ○ Hospital birth
- ○ Birthing center
- ○ Premature delivery
- ○ Greater than 12 hours
- ○ Complications
- ○ Fetal monitor used
- ○ Other-please explain: _____
- ○ Medications
- ○ Forceps
- ○ Cesarean

V. NEWBORN HISTORY

Pregnancy duration (weeks):_____ Birth length:_____ Birth weight: _____

Please check any of the following problems the patient had at birth:

○ Breathing ○ Coloring ○ Crying ○ Choking ○ Nursing

○ Sleeping ○ Jaundice ○ Other:_____

Breast fed: ○ Yes ○ No For how long? _____

Bottle fed: ○ Yes ○ No For how long? _____ Type of formula: _____

History of colic? ○ Yes ○ No Normal weight gain? ○ Yes ○ No

At what age were solid foods introduced?_____ What foods initially?_____

VI. IMMUNIZATIONS

Please check all immunizations the patient has received, at what age, and reactions, if any:

- ○ Diphtheria - Age/Reaction: _____
- ○ Pertussis - Age/Reaction: _____
- ○ Tetanus - Age/Reaction: _____
- ○ Polio - Age/Reaction: _____
- ○ Measles - Age/Reaction: _____
- ○ Mumps - Age/Reaction: _____
- ○ Chickenpox - Age/Reaction: _____
- ○ Rubella - Age/Reaction: _____
- ○ Other - Age/Reaction:_____
- ○ Other - Age/Reaction:_____

VII. HOSPITALIZATIONS AND ILLNESSES

Has the child ever been hospitalized or operated on? ○ Yes ○ No If so, explain: _____

Has the child ever had a serious accident (broken bones, head injuries, falls, burns, poisoning)? ○ Yes ○ No

If so, explain: _____

Has the child ever had any of the following illnesses:

- ○ Asthma
- ○ Pneumonia
- ○ Whooping cough
- ○ Hay fever
- ○ Bronchitis
- ○ Tuberculosis
- ○ Polio
- ○ Diphtheria
- ○ Measles
- ○ Mumps
- ○ Chickenpox
- ○ Rheumatic fever
- ○ Heart/blood vessel disease
- ○ Bleeding tendencies
- ○ Other: _____
- ○ Liver disease
- ○ Sickle cell disease
- ○ Epilepsy
- ○ Diabetes

VII. HOSPITALIZATIONS AND ILLNESSES CONTINUED

Does the child have any allergy problems (rash, itching, swelling, difficulty breathing, sneezing, etc)…

a) when eating food? ○ Yes ○ No What foods? _____

How does the child react? _____

b) when taking medication? ○ Yes ○ No What medications? _____

How does the child react? _____

c) when near animals, furs, insects, dust, etc? ○ Yes ○ No What things? _____

How does the child react? _____

d) at certain times of the year? ○ Yes ○ No When? _____

How does the child react? _____

VIII. GENERAL Please check all that apply.

○ Poor appetite	○ Cold hands	○ Insomnia	○ Localized weakness
○ Excess appetite	○ Cold feet	○ Heavy sleeper	○ Poor coordination
○ Change in appetite	○ Chills	○ Wakes in a foul mood	○ Vertigo
○ Food cravings	○ Fever	○ Irregular naps	○ Fatigue
○ Nail biting	○ Sweats easily	○ Night sweats	

○ Sudden energy drops; at what times? _____

○ Peculiar tastes/smells? _____

○ Bleed or bruise easily; where? _____

IX. SKIN AND HAIR Please check all that apply.

○ Rashes	○ Ulcerations	○ Psoriasis	○ Itching
○ Eczema	○ Pimples	○ Hives	
○ Change in hair/skin texture		○ Other hair or skin problems: _____	

_____

X. HEAD, EYES, EARS, NOSE, AND MOUTH Please check all that apply.

○ Dizziness	○ Spots in eyes	○ Nose bleeds	○ Gum problems
○ Concussions	○ Poor vision	○ Sinus problems	○ Dry throat
○ Facial pain	○ Blurry vision	○ Nasal congestion	○ Dry mouth
○ Eye strain	○ Corrective lenses	○ Sores on lips or tongue	○ Jaw clicks
○ Color blindness	○ Earaches	○ Teeth problems	
○ Night blindness	○ Ringing in ears	○ Grinding teeth	
○ Eye pain	○ Poor hearing	○ Recurrent sore throat _____/month	

○ Headaches; where & when? _____

_____

○ Other head or neck problems? _____

_____

XI. RESPIRATORY Please check all that apply.

○ Cough	○ Coughing blood	○ Tight chest
○ Difficulty in breathing when lying down		○ Recurrent colds/Flu:_____/month
○ Production of phlegm - color? _____		○ Other lung problems: _____

_____

XII. GASTROINTESTINAL Please check all that apply.

- ○ Nausea
- ○ Vomiting
- ○ Belching
- ○ Bad breath
- ○ Sensitive abdomen
- ○ Pain or cramps
- ○ Gas
- ○ Diarrhea
- ○ Bloody stools
- ○ Black stools
- ○ Constipation
- ○ Laxative use:_____/week; Type:_____
- ○ Rectal pain
- ○ Hemorrhoids
- ○ Other intestinal problems? _____

Bowel movement: Frequency:_____ Color:_____ Odor:_____Texture/form:_____

XIII. GENITO-URINARY Please check all that apply.

- ○ Pain on urination
- ○ Unable to hold urine
- ○ Frequent urination
- ○ Bedwetting
- ○ Blood in urine
- ○ Wakes to urinate - How often:_____/night
- ○ Urgency to urinate
- ○ Other intestinal problems? _____

XIV. MUSCULOSKELETAL Please check all that apply.

- ○ Neck pain
- ○ Back pain - where? _____
- ○ Muscle cramps
- ○ Joint pains - where? _____
- ○ Ticklish
- ○ Other joint or bone problems: _____

XV. NEUROPSYCHOLOGICAL Please check all that apply.

- ○ Fidgety (hands and feet)
- ○ Easily stressed/anxiety
- ○ Bad temper
- ○ Impatient
- ○ Seizures
- ○ Hyperactive
- ○ Difficulty completing tasks
- ○ Trouble with reading/concentrating
- ○ Depression
- ○ Treated for emotional problems - describe: _____
- ○ Other neurological or psychological problems: _____

XV. DIET AND NUTRITION Please check all that apply.

D=Daily F=Frequently O=Occasionally R=Rarely N=Never

D	F	O	R	N		D	F	O	R	N	
○	○	○	○	○	Fresh fruits	○	○	○	○	○	Fish
○	○	○	○	○	Fresh vegetables	○	○	○	○	○	Fowl
○	○	○	○	○	Raw foods	○	○	○	○	○	Red meats/cold cuts
○	○	○	○	○	Sprouted foods	○	○	○	○	○	White flour products
○	○	○	○	○	Whole grains	○	○	○	○	○	White rice/pasta products
○	○	○	○	○	Unrefined cereals	○	○	○	○	○	White sugar products
○	○	○	○	○	Legumes/beans	○	○	○	○	○	Artificial sweeteners
○	○	○	○	○	Nuts/seeds	○	○	○	○	○	Deep-fat fried foods
○	○	○	○	○	Dairy products	○	○	○	○	○	Fast foods
○	○	○	○	○	Peanut butter	○	○	○	○	○	Pre-packaged foods
○	○	○	○	○	Honey/molasses	○	○	○	○	○	Foods with preservatives
○	○	○	○	○	Fruit juices	○	○	○	○	○	Soda pop
○	○	○	○	○	Soy products	○	○	○	○	○	Chocolate
○	○	○	○	○	Eggs						

List vitamin and mineral supplements the child is currently taking: _____

_____

_____