**New Jersey Natural Medicine**
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## PEDIATRIC INTAKE FORM (Birth- 5 years)

Patient's name _____ Date of first visit _____
Age _____ Date of Birth _____ Gender: female _____ male _____
Mother's name_____ Father's name _____
Address _____ City _____ State _____
Phone # (home) (_____) _____ Parents work # (_____) _____
How did you hear about the practice? _____
Name of Dr.'s Office/Hospital/Clinic where your child's health records are kept _____
_____
Reason for referral or presenting problems _____
_____

| **MEDICATIONS** | Now | Past | | Now | Past |
|---|---|---|---|---|---|
| Aspirin | _____ | _____ | Antibiotics | _____ | _____ |
| Tylenol | _____ | _____ | Anti-histamine | _____ | _____ |
| Decongestant | _____ | _____ | Other | _____ | _____ |
| Ibuprofin | _____ | _____ | Allergies to medicines _____ | | |

**MEDICAL HISTORY**

_____ Chicken pox _____ Scarlet fever _____ Tonsillitis, approx. no. _____
_____ Measles _____ Pneumonia _____ Ear infections, no. _____
_____ Mumps _____ Frequent colds _____ other (please list) _____
_____ Rubella _____ Rheumatic fever

| Has your child had any of the following tests? | When | Where | Results |
|---|---|---|---|
| Electroencephalogram | ..... | ..... | ..... |
| Psychological evaluation | ..... | ..... | ..... |
| Hearing | ..... | ..... | ..... |
| Speech/Language | ..... | ..... | ..... |

Injuries/Surgeries/Hospitalizations (please list): _____
_____

**IMMUNIZATIONS**

_____ Measles _____ Polio _____ MMR _____ Smallpox _____ Diphtheria
_____ Mumps _____ DPT _____ Tetanus _____ Influenza
Others (list) _____

Any adverse reactions? Y N What ? _____

**FAMILY HISTORY**

_____ Heart disease _____ Diabetes _____ Birth defects
_____ Hypertension _____ Arthritis _____ Tuberculosis
_____ Cancer _____ Allergies _____ Mental illness

**PRENATAL HISTORY**

Previous pregnancies by natural mother, miscarriages, or complications?

Mother's age at child's birth? _____
Mother's health during pregnancy?

_____ Bleeding _____ Physical or emotional trauma
_____ Nausea _____ Cigarettes, alcohol, drug consumption
_____ Illnesses _____ Medications
_____ Hypertension _____ Thyroid problems _____ Diabetes

**BIRTH HISTORY**

Term: Full _____ Premature _____ Late _____ Weight at birth_____
Length of labor _____ Complications? _____
Did your child have any of the following problems shortly after birth?

_____ Birth defects _____ Birth injuries _____ Blue baby
_____ Cerebral palsy _____ Seizures _____ Jaundice
_____ Colic _____ Fever _____ Rashes

Other (explain) _____

Child's sleep patterns (first year) _____

Food intolerances (if any) _____

Feeding: Breast fed? _____ how long? _____

Formula? ____ milk / soy _____

Age began solids _____ Which foods? _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

**SYMPTOMS** (mark **Y** if current, **P** for past symptoms)

_____ Hives _____ Burning of urine _____ Bloody urine
_____ Eczema _____ Frequent urination _____ Cries easily
_____ Bleeding gums _____ Heart murmur _____ Nervous
_____ Nose bleeds _____ Vomiting spells _____ Sleep problems
_____ Acne _____ Anemia _____ Night sweats
_____ High fevers _____ Stomach aches _____ Sensitive to light

| | | |
|---|---|---|
| _____ Chronic rash | _____ Jaundice | _____ Body/breath odor |
| _____ Hearing loss | _____ Easy bruising | _____ Motion/car sickness |
| _____ Diarrhea | _____ Flat feet | _____ No appetite |
| _____ Sore throats | _____ Constipation | _____ Nightmares |
| _____ Headaches | _____ Gas | _____ Canker sores |
| _____ Frequent colds | _____ Bleeding tendency | _____ Unusual fears |
| _____ Wheezing | _____ Joint pains | _____ Excessive fatigue |
| _____ Cough | _____ Dizzy spells | _____ Hair loss |

**DIET**

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____ Dinner:

_____

Snacks: _____

To Drink: _____