NEW JERSEY NATURAL MEDICINE

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Pediatric Intake Form (Birth to 12 years)

Name_____ Date_____

Mothers Name_____ Fathers Name_____

Address_____

City_____ State_____ Zip code_____

Home Number_____ Cell_____

Email_____

Date of Birth_____ Age_____ Gender_____

How did you hear about our clinic? _____

Primary Care Physician_____ Phone_____

Insurance Carrier_____

Emergency Contact_____

Relationship_____ Phone_____

What are your most important health concerns? List as many as you can in order of importance:

1._____

2._____

3._____

4._____

Current Medications

Aspirin	__Y __N __P	Ibuprofen	__Y __N __P	Other_____
Tylenol	__Y __N __P	Antibiotics	__Y __N __P	_____
Decongestant	__Y __N __P	Antihistamine	__Y __N __P	

Medical History

(PLEASE MARK ONLY YES ANSWERS)

Scarlett Fever	_____	Diphtheria____	Rheumatic Fever_____
Mumps	_____	Measles_____	German Measles_____

Has your child had any of the following tests?

Electroencephalogram_____

Psychological Evaluation_____

Hearing Test _____

Speech /Language_____

Injuries_____

Surgeries_____

Hospitalizations_____

Family History

Do you have a family history of any of the following? **(PLEASE MARK ONLY YES ANSWERS)**

Cancer ___ Diabetes___ Heart Disease____ High Blood Pressure ___ Kidney Disease___

Epilepsy___ Arthritis____ Glaucoma_____ Tuberculosis_____ Stroke____

Anemia___ Asthma____ Hives_____ Hay Fever_____ Mental Illness____

Any other relevant family history? _____

_____

Immunizations

Polio _____ Diphtheria____ Rheumatic Fever_____
Mumps _____ Measles_____ German Measles_____
Others_____
Any adverse reactions? Y___ N___ What? _____
_____

Prenatal History

Previous Pregnancies by natural mother, miscarriages or complications? _____
_____

Mother's age at child's birth? _____

Mother's health during pregnancy? (Please only mark yes answers)

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

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? ___Y ___N how long? _____

Formula? ___Y ___N _____ milk / soy _____

Age began solids _____ Which foods? _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

What hospitalizations/Surgeries or Injuries has your child had?

_____

_____

_____

_____

_____

Allergies

Is your child hypersensitive or allergic to?

Any drugs?_____

Any foods?_____

Any environmentals? _____

Typical Food Intake

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Drinks_____

Please list any prescription medications, over the counter medications, vitamins or supplements your child is currently taking.

1._____ 4._____

2._____ 5._____

3._____ 6._____

REVIEW OF SYSTEMS

Y = a condition now **P** = a condition in the past **N** = never had

MENTAL/ EMOTIONAL

Mood Swings	__Y __N __P	Anxiety/nervousness	__Y __N __P
Irritability	__Y __N __P	Cries easily	__Y __N __P
Hyperactivity	__Y __N __P	Unusual fears	__Y __N __P
Introvert/extrovert	__Y __N __P	Sleep problems	__Y __N __P
Motion/car sickness	__Y __N __P	Nightmares	__Y __N __P

ENDOCRINE

Heat/cold intolerance	__Y __N __P	Fatigue	__Y __N __P
Excessive thirst	__Y __N __P	Excessive hunger	__Y __N __P
Low blood sugar	__Y __N __P	High blood sugar	__Y __N __P

SKIN

Rashes	__Y __N __P	Eczema, Hives	__Y __N __P
Acne, Boils	__Y __N __P	Itching	__Y __N __P

HEAD

Headaches	__Y __N __P	Head Injury	__Y __N __P
Dizzy spells	__Y __N __P	High fevers	__Y __N __P

EYES

Glasses or contacts	__Y __N __P	Tearing or dryness	__Y __N __P
Eye pain/strain	__Y __N __P		

EARS

Earaches	__Y __N __P	Impaired hearing	__Y __N __P

NOSE AND SINUSES

Frequent colds	__Y __N __P	Nose Bleeds	__Y __N __P
Stuffiness	__Y __N __P	Hay fever	__Y __N __P
Sinus problems	__Y __N __P	Loss of smell	__Y __N __P

MOUTH AND THROAT

Frequent sore throat	__Y __N __P	Canker sores	__Y __N __P
Breath odor	__Y __N __P		

RESPIRATORY

Cough	__Y __N __P	Wheezing	__Y __N __P
Asthma	__Y __N __P	Bronchitis	__Y __N __P

CARDIOVASCULAR

Heart disease	__Y __N __P	Murmurs	__Y __N __P

URINARY

Frequent urination	__Y __N __P	Bed wetting	__Y __N __P

GASTROINTESTINAL

Belching/passing gas	__Y __N __P	Stomach aches	__Y __N __P
Constipation	__Y __N __P	Diarrhea	__Y __N __P
Bowel Movements	How often _____		

MUSCULOSKELETAL

Joint pain/stiffness	__Y __N __P	Muscle spasms/cramps	__Y __N __P
Broken bones	__Y __N __P		

BLOOD/PERIPHERAL VASCULAR

Anemia	__Y __N __P	Easy bleeding/bruising	__Y __N __P

Is there any additional information about your child's health you would like to add?

_____
_____
_____
_____
_____