The Rocking Chair LLC

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NATUROPATHIC PEDIATRIC INTAKE FORM

Date: ____________________

Name:

____
Last *First* *M.I.*

Date of Birth: ____________________ **Age:** ________ **Gender:**(circle one) **F** **M**

Parent or Guardian: ______________ ______________ ______________
Father *Mother* *Guardian*

Address: ____

City: ______________ **State:** ______________ **Zip Code:** ______________

Telephone: Please circle the preferred number to contact you:

Home #: ______________ Work #: ______________ Cell #: ______________

E-mail: ______________________________

Currently, who is the child's primary care physician?

____

When was the child's last physical exam? ______________________

How were you referred to Dr. Sussman? ______________________

What are the child's health concerns, in order of importance:

1. ____
2. ____
3. ____
4. ____
5. ____

MEDICAL HISTORY

How would you describe the child's general state of health?

Excellent Good Fair Poor

Injuries/Surgeries/Hospitalizations (Describe and provide dates)

____
____
____

Medications: Check under **Now** for medications currently being taken and check under **Past** for medications taken at one time or another.

	Now	Past		Now	Past
Aspirin	____	____	*Asthma Medications*	____	____
Ibuprofen	____	____	*Decongestants*	____	____
Inhalers	____	____	*Topical Steroids*	____	____
Antibiotics	____	____	*Other*	____________	
Anti-histamine	____	____		____________	

Supplements (List all vitamins, minerals, herbs, etc. with the amounts of each):

____

____

Has your child ever had: (Check those that are applicable)

_____*Chicken pox*	____ *Scarlet fever*	____*Bronchitis*	____*Asthma*
_____ *Measles*	____ *Pneumonia*	____*Rubella*	____*Mumps*
_____*Frequent Colds*	____*Croup*	____*Whooping Cough*	

_____*Tonsillitis - How many times?* ____*Ear infections - How many?*____ *Other*____________

Symptoms:
Please circle: Y = a condition your child has now N = never had P = has had in the past

Hives	*Y P N*	*Burning of urine*	*Y P N*	*Bloody urine*	*Y P N*
Eczema	*Y P N*	*Frequent urination*	*Y P N*	*Cries easily*	*Y P N*
Bleeding gums	*Y P N*	*Heart Murmur*	*Y P N*	*Nervous*	*Y P N*
Nose bleeds	*Y P N*	*Vomiting spells*	*Y P N*	*Sleep problems*	*Y P N*
Acne	*Y P N*	*Anemia*	*Y P N*	*Night sweats*	*Y P N*
High fever	*Y P N*	*Stomach aches*	*Y P N*	*Sensitive to light*	*Y P N*
Chronic rash	*Y P N*	*Jaundice*	*Y P N*	*Body/Breath odor*	*Y P N*
Hearing loss	*Y P N*	*Easy bruising*	*Y P N*	*Motion/car sick*	*Y P N*
Diarrhea	*Y P N*	*Flat feet*	*Y P N*	*No appetite*	*Y P N*
Sore throats	*Y P N*	*Constipation*	*Y P N*	*Nightmares*	*Y P N*
Gas	*Y P N*	*Canker sores*	*Y P N*	*Wheezing*	*Y P N*
Joint pain	*Y P N*	*Cough*	*Y P N*	*Dizzy spells*	*Y P N*
Hair loss	*Y P N*	*Frequent Headaches*	*Y P N*	*Frequent colds*	*Y P N*
Unusual fears	*Y P N*	*Bleeding tendency*	*Y P N*	*Excessive fatigue*	*Y P N*

Does the child have any other condition not mentioned? ______________________

____

X-Rays and Special Studies:

When Where Results

Electroencephalogram: ______________________________

Psychological Evaluation: ______________________________

Hearing: ______________________________

Speech/Language: ______________________________

Injuries/Surgeries/Hospitalizations (Describe and provide dates):

____

____

____

Allergies: Does the child have any allergies to foods, drugs or other allergens in your environment (cats, mold, dust)? Yes _____ No _____ If yes, list and explain.

____

____

Antibiotics: How many times has the child been treated with antibiotics in their life? _________

Immunizations:

____*Measles*	____*Polio*	_____*MMR*	_____*Small Pox*	____*Hep B*
____*Mumps*	____*DPT*	_____*Tetanus*	_____*Influenza*	_______________*Other*

Please indicate if any vaccinations caused adverse reactions (i.e. diaper rash, fever, crying, cold):

____

____

PRENATAL HEALTH

What was the health of the parents at conception?

Mother:	Poor	Fair	Good	Excellent	Unknown
Father:	Poor	Fair	Good	Excellent	Unknown

What was the health of the mother during the pregnancy?

Poor Fair Good Excellent Unknown

What was the mother's age at the child's birth? ______________________

How was the mother's diet during pregnancy?

Poor Fair Good Excellent Unknown

Did the mother receive prenatal medical care? Y N Unknown

Did the mother experience any of the following during the pregnancy:

□ Bleeding □ High blood pressure □ Nausea □ Vomiting □ Diabetes

□ Thyroid problems □ Physical or emotional trauma □Other________________

Did the mother use any of the following during the pregnancy?

□ Tobacco □ Alcohol

□ Recreational drugs: ______________________________

□ Prescription medications: ______________________________
□ Over-the-counter medications: ______________________________
□ Supplements: ______________________________
□ Other: ______________________________

BIRTH HISTORY

Term length: □Full □Premature: ________wks □Late: ________wks

Length of Labor: ________________ Weight at birth:________________

Any complications?______________________________

Was the birth:
□Vaginal □C-section □Induced □Forceps used □Anesthesia used

Did the child experience any of the following at or shortly after birth?
□ Jaundice □ Rashes □ Seizures
□ Birth injuries: ______________________________
□ Birth defects: ______________________________
□ Other: ______________________________

DIET

How is/was the infant fed?
□ Breast fed: How long? ______________________________
□ Formula: Milk/soy/other: ______________________________
□ Other: ______________________________

What foods were introduced before 6 months? (Please list approximate month as well)

____
____

Between 6-12 months?

____
____

Did the child ever experience colic? Y N
How severe? □ mild □ moderate □ severe

Does the child have any food cravings or aversions? Y N If yes, please specify

____
____

Does the child have any dietary restrictions (religious, vegetarian/vegan, etc.)?

____
____

Describe a typical day's diet:
Breakfast: ___
Lunch: ___
Dinner: ___
Snacks: ___
Beverages (and total quantity): ___

Does the child have any food intolerances that you know of? Y N If yes, please explain

___

___

Please comment on the child's bowel movements (quantity/quality-color, blood, mucus, undigested food):

___

___

Please comment on the child's digestion (gas, bloating, etc):

___

___

HEALTH AND DEVELOPMENT

How was the child's health in the first year?
Poor Fair Good Excellent Unknown

At what age did the child first:
Sit up___ Crawl___ Walk ___ Talk___

Describe the child's sleep pattern:

___

___

Please comment on the child's temperament and general mood:

___

___

Describe the child's fears or phobias:

___

___

How would you describe the child's behavior and performance at school?

___

___

Please comment on the child's ability to interact with other children:

___

___

FAMILY HISTORY

Indicate if a close relative (parent, sibling) has had any of the following:

____*Alcoholism*	____*Asthma*	____*Eczema*	____*Mental Illness*
____*Allergies/Hay Fever*	____*Birth Defects*	____*Epilepsy*	____*Obesity*
____*Anemia*	____*Cancer*	____*Heart Disease*	____*Stroke*
____*Arthritis*	____*Diabetes*	____*Hypertension*	____*Thyroid Disorder*
		____*Kidney Disease*	____*Tuberculosis*

*Other (please explain)*____

□ I don't know the family medical history.

Do either of the parents have a chronic illness? Y N Please describe:

____

____

ENVIRONMENT

Is the child in school, daycare, home care, other? If so, how many hours per week?

____

What are the child's favorite activities? ____

____

Does the child exercise regularly? Y N If yes, how much and how often?

____

____

How much television does the child watch? __________Hrs per day/week

How often does the child read, or how often does someone read to the child?

□ Daily □ Several times a week □ Weekly □Less than weekly

Does anyone in the child's household smoke? Y N

Are there animals in the home? Y N

How is the child's home heated? □ natural gas □ oil □ electric □ wood

How would you describe the emotional climate of the child's home?

____

____

Number and age of siblings, and how does the child interact with them?

____

____

Is there anything that you feel is important that has not been covered?

____

____