Nature's Helper
NATUROPATHIC MEDICINE

Pediatric Intake - Under 15

Patient Name:_____ DOB:_____

Parent's Names:_____

Please list in order of importance the health concerns that you would like addressed:
1) _____ 2)_____
3) _____ 4)_____

Has child been seen by any other doctor(s) for this complaint? Y N Past

List All **Surgeries & Hospitalizations**, including date occurred:
1) _____ 2) _____

List All **medicines/supplements**:
1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Known **Allergies** to foods, drugs, environment, and animals:_____

_____

_____

Previous Medical History

YES (Y) indicates the child gets the problem regularly; **NO (N)** indicates the child has never had the problem; **PAST (P)** indicates that the child had the problem in the past, but not recently.

Ear infections: Y N P
Frequent infections: Y N P
Strep Throat: Y N P
Asthma: Y N P
Diarrhea/Constipation: Y N P
Finicky Eating: Y N P
Breast Fed: Y N How long_____

Colic: Y N P
Skin Rashes: Y N P
Bed-wetting: Y N P
Anemia: Y N P
Stomach aches: Y N P
Early Puberty: Y N P

Has your child taken antibiotics frequently: Y N P

Hearing normal: Y N Not tested **Vision normal**: Y N Not tested

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Did your child receive all available vaccinations? Y N
If not, please explain_____

Family History of Parents and 1st Degree Relatives:

Allergies Y N	Asthma Y N
Obesity Y N	Mental Illness Y N
High Blood Pressure Y N	High Cholesterol Y N
Heart Attack/Stroke Y N	Substance Abuse Y N
Diabetes mellitus Y N	Cancer Y N
Autoimmune Disease Y N	Thyroid Disease Y N

Mother's Health During Pregnancy

Smoking: Y N **Coffee**: Y N **Recreational drugs**: Y N
Emotional Stress: Y N **Preeclampsia**: Y N **Gestational Diabetes**: Y N

Vaginal Birth: Y N **Traumatic birth**: Y N **If yes please explain**:

_____

Social History:

Who lives at home with the child:_____

Sports or after school activities:_____

Other hobbies:_____

Typical Day's Diet

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Beverages:_____