Pediatric Health Intake

Preferred method of communication: ☐ Phone ☐ Email

Name: _____ Date of Birth: _____ Sex: _____ Age: _____

Mother's name: _____ Father's name: _____

Parents' marital status: _____ Blood Type: ____ Current grade in school: _____

Health Concerns: Please list in order of importance. Rate severity (1 is low, 10 is high) and success (1 is no success, 10 is very successful)

Concern	Severity (1-10)	Past/Present Treatments	Success (1-10)

Is the child currently under the care of a physician? Yes / No

If yes, with whom? Specialty? What condition? _____

If no, when did the child last receive medical care? _____

Date of last well child exam and any significant findings: _____

Known drug, food, or environmental allergies with reaction: _____

Medications/Supplements

Current

Name	Strength	Dosage	Reason	Duration

Past (Within the last six months; circle any that apply)

Pain Relievers	Appetite suppressants	Hormones	Sedatives	Thyroid
Antacids	Birth Control	Insulin	Sleeping	Antidepressants
Antibiotics	Blood Pressure	Laxatives	Steroids	Supplements:

Past Medical History

Previous Medical Diagnoses or Conditions with year diagnosed: _____

_____

Birth History

Mother's age at conception: _____ Did she have other children? Yes / No Number of children in family: _____

Mother's health during pregnancy (circle any that apply):

Diabetes	Caffeine	Nausea/Vomiting
Hypertension	Alcohol	Emotional stress
Smoking	Recreational drugs	Medications: _____

Vaginal or Caesarean birth (circle one) Number of weeks at delivery: _____ Birth weight: _____

Labor was Spontaneous or Induced (circle one). If induced, explain: _____

Labor was in Hospital or Other (circle one). If other, explain: _____

Number of hours of labor: _____ Birth difficulties: _____

Breastfed or Bottle-fed (circle). If bottle-fed, formula type: _____

If breastfed, for how long: _____

Feeding problems: _____

Age of - Solid food introduction: _____ Walk: _____ Talk: _____ First teeth: _____

Childhood Illnesses and Vaccinations

Illness	Yes, had it	No, never had it	Vaccinated	Illness	Yes, had it	No, never had it	Vaccinated
Scarlet Fever				Smallpox			
Mumps				Pertussis			
Measles				Polio			
Rubella				Tetanus			
Rheumatic Fever				Hepatitis B			
Diptheria				Influenza			
Chicken Pox				Meningitis			
Shingles				HPV			

Vaccine reactions: _____

Surgeries with year:_____

Hospitalizations with year and reason: _____

Diagnostic Procedures (Ultrasound, X-ray, CT/MRI) with year and reason: _____

Family History

	Age if Living	Age of Death	Health Problems (cancers, diabetes, cardiovascular disease, thyroid disease, autoimmune disease, osteoporosis)
Mother			
Maternal Grandmother			
Maternal Grandfather			
Father			
Paternal Grandmother			
Paternal Grandfather			
Siblings			

Social History

With whom does the child live? _____ Pets: _____ Indoor/Outdoor

Has the child lived or traveled outside the US? If so, where, and when? _____

Typical Breakfast: _____ Time: _____

Lunch: _____ Time: _____

Dinner: _____ Time: _____

Snacks: _____ Time(s): _____

Dietary restrictions or food aversions: _____ Food cravings: _____

Water intake (oz/day): _____ Coffee (cups/day): _____ Tea (type, cups/day): _____

Soda (diet, regular, #/day): _____ Milk (type, %fat): _____

Exercise: Yes / No Type(s): _____ Frequency: _____ Duration: _____

Interests and Hobbies: _____ Watch television? Yes / No Hours/night: _____

Sleep

Time to bed: _____ Hours/night: _____ Wake refreshed? Yes / No Fall asleep easily (within 10 min)? Yes / No

Wake at night? Yes / No Time/Reason: _____ Snore or stop breathing during sleep? Yes / No

Concerns about sleep: _____ Energy (1-10, 10 is best): _____

Stress (1-10, 10 is most severe): _____ Sources of stress: _____

Does the child have tools to manage stress? Yes / No

Environmental History
Please indicate if you have any current or past exposure to the following:

Exposure	Current	Past	Reaction	Exposure	Current	Past	Reaction
Leaded paint				Industrial fumes/ chemicals			
Near refinery or industry				Perfume sensitivity			
New carpet/paint/etc				Detergent sensitivity			
Pesticide/Insecticide use				Radiation			
Dry cleaning				Infectious			
Smoking in household or work environment				Mercury fillings? Number? How many removed?			
Solvent exposure				Root canals? Number removed?			
Heavy metals				Other			

Other Concerns (please describe):

Review of Systems

(Y)=currently have or had *within the last 6 months*, (N)=never had, (P)=had *more than 6 months ago*

Fatigue	Y	N	P	Lightheadedness	Y	N	P	Nosebleeds	Y	N	P	Pain with urination	Y	N	P
Daytime sleepiness	Y	N	P	Fainting	Y	N	P	Sinus infection	Y	N	P	Urinary frequency	Y	N	P
Early waking	Y	N	P	Nerve pain	Y	N	P	Bad breath	Y	N	P	Urinary urgency	Y	N	P
Fever	Y	N	P	Tremor	Y	N	P	Cough	Y	N	P	Incontinence	Y	N	P
Flushing	Y	N	P	Rash	Y	N	P	Phlegm	Y	N	P	Wake to urinate	Y	N	P
Night sweats	Y	N	P	Eczema	Y	N	P	Asthma	Y	N	P	Urinary hesitancy	Y	N	P
Sleepwalking	Y	N	P	Psoriasis	Y	N	P	Shortness of breath	Y	N	P	Kidney disease/stones	Y	N	P
Nightmares	Y	N	P	Hives	Y	N	P	Heart palpitations	Y	N	P	Blood in urine	Y	N	P
No dream recall	Y	N	P	Acne	Y	N	P	Chest pain	Y	N	P	Bedwetting	Y	N	P
Unintended weight loss	Y	N	P	Excess hair loss	Y	N	P	Low blood pressure	Y	N	P	MALE			
Chronic infection	Y	N	P	Itching	Y	N	P	Heart murmur	Y	N	P	Testicular pain	Y	N	P
Swollen lymph nodes	Y	N	P	Fungal infections	Y	N	P	Swelling in ankles/feet	Y	N	P	Testicular mass	Y	N	P
Slow wound healing	Y	N	P	Weak or brittle nails	Y	N	P	Easy bruising	Y	N	P	Prostate problems	Y	N	P
Hot / Cold intolerance	Y	N	P	Headache	Y	N	P	Anemia	Y	N	P	FEMALE			
Hyper / Hypo glycemia	Y	N	P	Migraine	Y	N	P	Varicose veins	Y	N	P	Age at menarche:			
Excess thirst	Y	N	P	Head injury	Y	N	P	Hemorrhoids	Y	N	P	Date of last menses:			
Excess hunger	Y	N	P	Jaw/TMJ problems	Y	N	P	Heartburn/Reflux	Y	N	P	Days of bleeding:			
Cold hands and feet	Y	N	P	Teeth grinding	Y	N	P	Nausea/Vomiting	Y	N	P	Cycle length (days):			
Difficulty concentrating	Y	N	P	Dental problems	Y	N	P	Gas or bloating	Y	N	P	Painful menses	Y	N	P
Mood swings	Y	N	P	Gum problems	Y	N	P	Abdominal pain	Y	N	P	Heavy menses	Y	N	P
Memory problems	Y	N	P	Eye infections	Y	N	P	Blood in stool	Y	N	P	Light menses	Y	N	P
Depression	Y	N	P	Vision problems	Y	N	P	Mucus in stool	Y	N	P	Bleeding mid-cycle	Y	N	P
Anxiety/Nervousness	Y	N	P	Eye tearing/dryness	Y	N	P	How often have a bowel movement:				Abnormal vaginal discharge/itching	Y	N	P
Panic attacks	Y	N	P	Eye pain/strain	Y	N	P	Diarrhea	Y	N	P	Abnormal pap	Y	N	P
Suicidal thoughts	Y	N	P	Impaired hearing	Y	N	P	Constipation	Y	N	P	Pain with penetration	Y	N	P
Seizures	Y	N	P	Ringing in ears	Y	N	P	Black or tarry stool	Y	N	P	Number of pregnancies:			
Paralysis	Y	N	P	Ear pain	Y	N	P	Gall bladder problems	Y	N	P	Number of miscarriages:			
Joint pain/arthritis	Y	N	P	Frequent sore throat	Y	N	P	Jaundice	Y	N	P	Difficulty conceiving	Y	N	P
Muscle pain/spasm	Y	N	P	Dry mouth	Y	N	P	Ulcer	Y	N	P	Breast lumps or cysts	Y	N	P
Numbness/tingling	Y	N	P	Difficulty swallowing	Y	N	P	Food intolerance	Y	N	P	Breast pain/tenderness	Y	N	P
Vertigo/Dizziness	Y	N	P	Cold sores	Y	N	P	Bladder pain	Y	N	P	Nipple discharge	Y	N	P

Context of Care Questionnaire

1. Why did you choose to come see me?

What do you know about my approach?

2. What 3 expectations do you have about this first visit?

1.

2.

3.

What long-term expectations do you have about working with naturopathic medicine?

What expectations do you have of me personally as your naturopathic doctor?

3. What is your and your child's present level of commitment to address any underlying causes of your signs and symptoms that relate to your child's lifestyle? (0-10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

4. What behaviors or lifestyle habits does your child currently engage in regularly that you believe support her/his health?

What behaviors or lifestyle habits does your child currently engage in regularly that you believe are self-destructive?

5. What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your child's health and in adhering to the therapeutic protocols which I will be sharing with you both?

6. Does your child know someone who will sincerely and consistently support her/him with the beneficial lifestyle changes she/he will be making?

7. What does your child LOVE to do?

In seeking care from Michelle Crowder, Naturopathic Doctor, I understand the following:

1. The State of Michigan does not currently regulate or license Naturopathic Physicians or the practice of Naturopathic Medicine. Therefore, Michelle Crowder, ND cannot diagnose, treat, or cure any condition. Instead, she provides health information and recommendations.

2. Michelle Crowder, ND is licensed in the State of Oregon and regulated by the Oregon Board of Naturopathic Medicine.

3. I should remain under the care of my primary care physician and will discuss any changes to my current medications or treatment with my primary care physician.

4. My consultations with Michelle Crowder, ND are confidential and will not be disclosed except where required by law or with prior authorization.

5. Payment is due at the time of service.

6. Because Naturopathic Physicians are not currently licensed in the state of Michigan, their services may not be covered under a Health Savings Account or Flex Spending Account. If you chose to use these methods as forms of payment, it is at your own risk.

7. If you would like to submit a claim to your insurance company for services provided by Michelle Crowder, ND, you must obtain proper documentation. Please inquire.

8. No Show Policy: Please allow at least 24 hours notice if you need to reschedule or cancel your appointment. Missed appointments are subject to the following fees: $170 for new patient visits; $90 for follow-up visits.

9. Email is not a secure form of communication. If I choose to communicate with Michelle Crowder, ND via this method, she is not responsible for any lost or compromised information.

10. If you would like Michelle Crowder, ND to communicate about your care with other physicians or practitioners, please provide their contact information below:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Signed: _____ Date: _____

Printed Name: _____