Troy Naturopathic

Website: www.troynaturopathic.com
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Phone: (248) 906-8889

PEDIATRIC INTAKE FORM

PLEASE COMPLETE THIS FORM AND BRING IT TO YOUR INITIAL APPOINTMENT

Child's First Name: _____ Last Name: _____ Date: _____/_____/_____

Form Filled by (Name): _____Relationship to Child: _____ Sex: ☐ Male ☐ Female

Date of Birth: _____/_____/_____ (MM/DD/YYYY) Child Lives with: _____ Relationship: _____

Child's Address: _____
Street City State Zip Code

Child's Guardians:

1. First Name: _____ Last Name: _____ Relationship: _____

Phone: (HOME) (_____) _____ (WORK) (_____) _____ (CELL) (_____) _____

2. First Name: _____ Last Name: _____ Relationship: _____

Phone: (HOME) (_____) _____ (WORK) (_____) _____ (CELL) (_____) _____

Emergency contact: _____ Phone: (_____) _____ Relationship to Patient: _____

With whom may we leave messages relating to your child's visits? _____ Where? ☐ Home ☐ Work ☐ Cell

Please list the other healthcare providers you are seeing:

Name: Type of Practitioner: **GP / Primary Care Physician** Address: Phone: Fax:	Name: Type of Practitioner: Address: Phone: Fax:
Name: Type of Practitioner: Address: Phone: Fax:	Name: Type of Practitioner: Address: Phone: Fax:

Please list, in order of importance, your child's health concerns:

1. _____ 2. _____

3. _____ 4. _____

Child's Medical History:

Please list all of the child's current and past medications & supplements in the medications / supplements form.

How many times has your child been treated with antibiotics? ☐ 1-2 ☐ 2-5 ☐ 5-10 ☐ 10-15 ☐ > 15

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Please indicate any **serious** conditions, illnesses or injuries and any hospitalizations, along with approximate dates.

Condition / Illness / Injury / Hospitalization	Date

Does your child have any allergies / intolerances / sensitivities (medicines, environmental, food etc.)?

Allergy / Intolerance / Sensitivity to:	Please describe your reaction

Does your child have any of the following dietary restrictions?

☐ Gluten-free ☐ Sugar-free ☐ Soy-free ☐ Vegan ☐ Vegetarian ☐ Other _____

Please indicate which immunizations your child has had:

☐ DPT (diphtheria, pertussis, tetanus)	☐ Haemophilus influenza B	☐ Hepatitis A	☐ Polio	☐ MMRV (measles, mumps, rubella, varicella)
☐ Tetanus booster, when? _____	☐ "Flu"	☐ Hepatitis B	☐ Smallpox	

Other immunizations not listed: _____

Please indicate if any caused adverse reactions: _____

Which of the following illnesses has your child had? (M – Mild / A – Average / S - Severe)

☐ **Rubella (German measles)**	☐ M ☐ A ☐ S	☐ **Impetigo**	☐ M ☐ A ☐ S	☐ **Roseola**	☐ M ☐ A ☐ S
☐ **Measles**	☐ M ☐ A ☐ S	☐ **Mononucleosis**	☐ M ☐ A ☐ S	☐ **Scarlet Fever**	☐ M ☐ A ☐ S
☐ **Chicken Pox**	☐ M ☐ A ☐ S	☐ **Ear Infections**	☐ M ☐ A ☐ S	☐ **Strep Throat**	☐ M ☐ A ☐ S
☐ **Whooping Cough**	☐ M ☐ A ☐ S	☐ **Mumps**	☐ M ☐ A ☐ S	☐ **Impetigo**	☐ M ☐ A ☐ S

Other Illnesses: _____

FAMILY HISTORY: (Please indicate the family member's age & whether they are living/deceased)

PGF = Paternal Grandfather..... ☐ Living ☐ Current age? _____ ☐ Deceased ☐ At what age? _____

PGM = Paternal Grandmother..... ☐ Living ☐ Current age? _____ ☐ Deceased ☐ At what age? _____

MGM = Maternal Grandmother..... ☐ Living ☐ Current age? _____ ☐ Deceased ☐ At what age? _____

MGF = Maternal Grandfather..... ☐ Living ☐ Current age? _____ ☐ Deceased ☐ At what age? _____

M = Mother ..... ☐ Living ☐ Current age? _____ ☐ Deceased ☐ At what age? _____

F = Father ..... ☐ Living ☐ Current age? _____ ☐ Deceased ☐ At what age? _____

S = Sister **B** = Brother **MA** = Maternal Aunt **PA** = Paternal Aunt **PU** = Paternal uncle **MU** = Maternal Uncle

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Please indicate if a close relative has/had any of the following: (Use the above abbreviations)

	Indicate which family member(s)		Indicate which family member(s)
Allergies		Diabetes	
Asthma		Depression	
Heart Disease		Alzheimer's	
High Blood Pressure		Drug Abuse/Alcoholism	
Cancer		Kidney Disease	

Do you or a family member have any major medical conditions not covered in the above chart?

_____

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 child's birth? _____

How was the mother's diet during pregnancy? ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Unknown

Did the mother receive prenatal medical care? ☐ YES ☐ NO ☐ Unknown

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

☐ Bleeding ☐ High Blood Pressure ☐ Nausea ☐ Vomiting ☐ Physical or emotional trauma ☐ Diabetes ☐ Thyroid issues

Other? Please explain:_____

Did the mother use any of the following during the pregnancy? (Check all that apply)

☐ Tobacco ☐ Alcohol ☐ Recreational drugs ☐ Prescription medications ☐ Over-the-counter medications ☐ Supplements

Please list: _____

BIRTH HISTORY:

Term length: ☐ Full ☐ Premature: ____ wks ____ days ☐ Late: ____ wks ____ days Length of labor: _____ hrs

Weight at birth: _____lbs _____ounces Delivery: ☐ Vaginal ☐ C-section ☐ Induced ☐ Forceps

Were there any complications? _____

Was anesthesia used? ☐ YES ☐ NO ☐ Unknown

Did the child experience any of the following at or shortly after birth? (Check all that apply)

☐ Jaundice ☐ Rashes ☐ Seizures ☐ Birth injuries ☐ Birth defects ☐ Other_____

Please explain: _____

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How was your infant fed?

☐ Breast fed How long? _____months ☐ Formula How long? _____months ☐ Both Breast Fed & Formula How long? _____months ☐ Other _____

What foods were introduced before 6 months?

Food	Approximate Month Introduced	Food	Approximate Month Introduced
1.		4.	
2.		5.	
3.		6.	

What foods were introduced 6–12 months? (Please list)

_____

_____

Did your child ever have colic? ☐ YES ☐ NO ☐ Unknown How severe was the colic? ☐ Mild ☐ Moderate ☐ Severe

HEALTH & DEVELOPMENT:

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

At what age did your child first: Sit up _____months Crawl _____months Walk _____months Talk _____months

Describe your child's sleep pattern:

_____

_____

How would you describe your child's temperament? _____

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

_____

ENVIRONMENT:

Is your child in daycare or other homecare? ☐ YES ☐ NO Explain: _____

What are your child's favorite activities?

_____

Does your child exercise regularly? ☐ YES ☐ NO

Type of Exercise	How often?	Type of Exercise	How often?
1.		3.	
2.		4.	

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How much television does your child watch? ☐ 0-1 hr/day ☐ 1-2 hrs/day ☐ 2-3 hrs/day ☐ 3-4 hrs/day ☐ >4 hrs/day

Is the child exposed to significant tobacco smoke? ☐ YES ☐ NO Where? ☐ Home ☐ Other _____

Is the child frequently exposed to animals? ☐ YES ☐ NO Where? ☐ Home ☐ Other _____

Is the child regularly exposed to toxins or other hazards? ☐ YES ☐ NO Where? ☐ Home ☐ Other _____

Which toxins? _____

Is there anything that you feel is important that has not been covered pertinent to the child's health?

_____

_____

_____

_____

How did you hear about Troy Naturopathic Clinic?

☐ Referral _____ ☐ Google Search ☐ Other_____