

Makai Naturopathic Center

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PEDIATRIC INTAKE FORM (6- 12 years)

Name _____ Date of first visit _____
Age _____ Date of Birth _____ Gender: female _____ male _____
Mother's name _____ Father's name _____
Address _____ City _____ State _____
Phone # (home) (_____) _____ Parents work # (_____) _____
How did you hear about this clinic? _____
Name of Dr.'s Office/Hospital/Clinic where your child's health records are kept _____

Reason for referral or presenting problems _____

What are your child's most important health problems? List as many as you can in order of importance.

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Does your child have a contagious disease at this time? Y N

If yes, what? _____

ALLERGIES

Is your child hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Anything environmental? _____

Breast-fed? _____ how long? _____ Formula? _____ milk / soy _____

MEDICATIONS

	Now	Past		Now	Past
Aspirin	_____	_____	Antibiotics	_____	_____
Tylenol	_____	_____	Anti-histamine	_____	_____
Decongestant	_____	_____	Other	_____	
Ibuprofen	_____	_____	Allergies to medicines	_____	

MEDICAL HISTORY

_____ Chicken pox	_____	Scarlet fever	_____	Tonsillitis (how often)	_____
_____ Measles	_____	Pneumonia	_____	Ear infections (how often)	_____
_____ Mumps	_____	Frequent colds	_____	other (please list)	_____
_____ Rubella	_____	Rheumatic fever			

Has your child had any of the following tests? When Where Results
 Electroencephalogram.....
 Psychological evaluation.....
 Hearing
 Speech/Language.....
 Injuries/Surgeries/Hospitalizations (please list): _____

IMMUNIZATIONS

____ MMR ____ Polio ____ Hib ____ Smallpox ____ Chicken Pox
 ____ Hep B ____ DPT ____ Tetanus ____ Prevnar
 Others (list) _____
 Any adverse reactions? Y N What ? _____

FAMILY HISTORY

____ Heart disease ____ Diabetes ____ Birth defects
 ____ Hypertension ____ Arthritis ____ Tuberculosis
 ____ Cancer ____ Allergies ____ Mental illness

TYPICAL DIET

Please describe your child's typical daily diet:
 Breakfast: _____
 Lunch: _____
 Dinner: _____
 Snacks: _____
 To Drink: _____

What foods have you found that your child has reactions to?

List any food that your child craves

List any foods that your child greatly dislikes

Is your child thirsty ? Yes No What temperature liquid do they prefer ? _____
 How much do they drink daily ? _____

What type of water do you normally use?
 Well Spring Distilled Filtered De-ionized Tap

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

- 1) _____ 4) _____
- 2) _____ 5) _____
- 3) _____ 6) _____

REVIEW OF SYSTEMS

Please check any of the following conditions your child currently has (C box), has had in the past (P box), or has never had (N box). Please also check if you feel any of the following are a significant part of your child's medical history.

LIFESTYLE

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cries easily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unusual fears

ENDOCRINE

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heat or cold intolerance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive hunger
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue

IMMUNE

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic fatigue syndrome
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronically swollen glands
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reactions to vaccines
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High fevers

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic infections
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow wound healing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reactions to immunizations
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

NEUROLOGIC

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo or dizziness

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heat or cold intolerance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numb/Tingling extremities
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of memory
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty concentrating

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acne
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair loss

SKIN

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic rash
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraines

HEAD

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaw/TMJ problems

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impaired hearing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Earaches

EARS

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ringings in the ears/ Tinnitus
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/ car sickness

EYES**C P N**

		Spots in eyes
		Impaired vision
		Blurriness
		Color blindness
		Double vision

C P N

		Cataracts
		Glasses or contacts
		Eye strain/pain
		Tearing or dryness
		Glaucoma

NOSE & SINUSES**C P N**

		Frequent colds
		Stuffiness or post-nasal drip
		Sinus problems

C P N

		Nose bleeds
		Hayfever
		Loss of smell

MOUTH & THROAT**C P N**

		Frequent sore throat
		Teeth grinding
		Gum problems/bleeding gums
		Dental cavities

C P N

		Copious saliva
		Sore tongue/lips, canker sores
		Hoarseness
		Jaw clicks

RESPIRATORY**C P N**

		Cough
		Spitting up blood
		Asthma
		Pneumonia
		Shortness of breath at night
		Pain on breathing

C P N

		Sputum
		Wheezing
		Bronchitis
		Shortness of breath lying down
		Difficulty breathing
		Shortness of breath

CARDIOVASCULAR/ PERIPHERAL VASCULAR**C P N**

		High/low blood pressure
		Blood clots
		Anemia

C P N

		Murmurs
		Fainting
		Easy bruising

GASTROINTESTINAL**C P N**

		Trouble swallowing
		Reflux
		Heartburn
		Vomiting blood
		Nausea
		Change in appetite
		Vomiting
		Belching or passing gas

C P N

		Constipation
		Diarrhea
		Blood with stool
		Change in bowel movements
		Abdominal pain or cramps
		No appetite
		Black stools
		Jaundice

URINARY

C	P	N	
			Pain on urination
			Increased frequency
			Frequent infections

C	P	N	
			Frequency at night
			Inability to hold urine/urgency
			Bloody urine

MUSCULOSKELETAL

C	P	N	
			Joint pain or stiffness
			Broken bones
			Muscle spasms or cramps

C	P	N	
			Arthritis
			Weakness
			Flat feet

LIVING ENVIRONMENT

Which of the following are used routinely in your home?

Forced air Radiant heat Air Conditioning Electric Blanket Wood Stove
 Oil Heat Gas heat Electric Heat Microwave Television
 Computer screen Cigarettes Feather Pillow

Has your child had any exposure to a toxic chemical or solvent ? _____

Has your child experienced any major grief or loss in their life ?

Does your child have any fears ? Are they unmanageable ?

Welcome! We're glad to be of service for you and your child!