

## NEW PEDIATRIC PATIENT INTAKE

All questions contained in this questionnaire are strictly confidential and will become part of your child's medical record

<b>Patient Name:</b>	<b>DOB:</b>	<input type="checkbox"/> F <input type="checkbox"/> M	<b>Today's Date:</b>
----------------------	-------------	---	----------------------

**Parent/Guardian Name(s):**

---

**What is your main reason for bringing your child to the clinic today?**

### MEDICAL & HEALTH HISTORY

**Immunizations and Date/Age Received:**

MMR       DPT       Chicken Pox       Influenza       Tetanus (alone)  
 Small Pox       Hepatitis       Polio       HPV       Other(s)

Adverse Reactions (if any):

---

**ANY KNOWN FOOD OR DRUG ALLERGIES:**

**Illnesses:**  Measles    Mumps    Rubella    Chicken Pox    Rheumatic Fever    Pneumonia  
 Frequent Colds    Strep Throat \_\_\_\_\_    Ear Infections, # of times \_\_\_\_\_    Tonsillitis, # of times \_\_\_\_\_  
 Other diagnosed medical problems or illnesses: \_\_\_\_\_

**Hospitalizations:** \_\_\_\_\_

Diagnostic Testing	Year	Location/Doctor
--------------------	------	-----------------

Electroencephalogram (EEG) \_\_\_\_\_

Psychological Evaluation \_\_\_\_\_

Hearing Testing \_\_\_\_\_

Speech/Language Testing \_\_\_\_\_

Other \_\_\_\_\_

**Please list below any prescription and non-prescription medicines used in the past or currently:**

Medicines	Current Usage	Past Usage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Family History (Grandparents, Parents, Siblings)**

Heart Disease    Diabetes    Birth Defects \_\_\_\_\_    Hypertension    Arthritis    Tuberculosis    Cancer  
 Allergies    Asthma    Osteoporosis    Mental Illness    Other Significant Illness \_\_\_\_\_

The Center for Natural Medicine, Inc.

1330 SE Cesar E Chavez Blvd (39th), Portland, OR 97214 ♦ (503) 232-1100 ♦ fax (503) 232-7751 ♦ www.cnmwellness.com

**Prenatal, Birth & Neonatal History**

Mother's age at time of gestation: \_\_\_\_\_ Previous pregnancies by natural mother: \_\_\_\_\_

Mother's health during pregnancy: Bleeding Nausea Hypertension Tobacco, Alcohol, Drug Use

Diabetes Thyroid Problems Illness \_\_\_\_\_

Physical or Emotional Trauma Medications \_\_\_\_\_

Gestation Term: Full Premature \_\_\_\_\_ Late \_\_\_\_\_ Birth Weight \_\_\_\_\_

Length of Labor \_\_\_\_\_ APGAR score \_\_\_\_\_ Complications (if any) \_\_\_\_\_

Birth Injuries Blue Baby Jaundice Defects \_\_\_\_\_

Seizures Fever Rash Colic Cerebral Palsy Feeding Problems

Other \_\_\_\_\_

Breast Fed? \_\_\_\_\_ How long? \_\_\_\_\_ Formula Fed? \_\_\_\_\_ Type \_\_\_\_\_ How long? \_\_\_\_\_

Began solid foods: \_\_\_\_\_ months First Foods: \_\_\_\_\_

Age Began: Sitting \_\_\_\_\_ Crawling \_\_\_\_\_ Walking \_\_\_\_\_ Talking \_\_\_\_\_

**SYMPTOMS** – Please mark **C** for current symptoms and **P** for symptoms experienced in the past:

- |                         |                       |                     |                       |
|-------------------------|-----------------------|---------------------|-----------------------|
| _____ Jaundice          | _____ Burning Urine   | _____ Constipation  | _____ Light Sensitive |
| _____ Hives             | _____ Bloody Urine    | _____ Diarrhea      | _____ Nightmares      |
| _____ Eczema            | _____ Easy Bruising   | _____ Stomach Ache  | _____ Bedwetting      |
| _____ Rashes            | _____ Vomiting Spells | _____ Poor Appetite | _____ Night Sweats    |
| _____ Allergic Reaction | _____ High Fevers     | _____ Joint Pain    | _____ Nervousness     |
| _____ Bad Breath        | _____ Dizzy Spells    | _____ Fatigue       | _____ Unusual Fears   |
| _____ Body Odor         | _____ Sore Throat     | _____ Coughing      | _____ Cries Easily    |
| _____ Acne              | _____ Headache        | _____ Wheezing      | _____ Other           |
| _____ Hair Loss         | _____ Nose Bleeds     | _____ Heart Murmur  | _____                 |

**TYPICAL DIET**

**Please list examples of foods/drinks your child regularly consumes below:**

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Beverages \_\_\_\_\_

What are your child's favorite foods? \_\_\_\_\_

**Other Health Issues**

Please describe your child's sleep pattern, including naps: \_\_\_\_\_

How would you describe your child's natural temperament? \_\_\_\_\_

Any recent changes in:  Weight  Appetite  Sleep  Energy Level  Behavior  Other

Please Describe: \_\_\_\_\_

\_\_\_\_\_