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

NEW PEDIATRIC PATIENT INTAKE

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

Patient Name:	**DOB:**	☐ F ☐ M	**Today's Date:**

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 _____

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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: _____

_____