


GreenNHouse
Naturopathic Medicine, LLC
Pediatric Intake Form

Julia Greenspan, ND

***Patient Note:** This is a confidential record of your medical history. It will not be released except with your authorization. Please complete this questionnaire as thoroughly as possible. Mark anything you do not understand with a question mark. Thank you.*

*** If mailing please return to P.O. Box 985, Hollis, NH 03049*

Financial Agreement

I claim full financial responsibility for services rendered by GreenNHouse Naturopathic Medicine, LLC and understand payment is required at the time of service.

Signature

Date

Child's Name _____ Today's Date _____
Child's Age _____ Date of birth _____ (M/D/Y) Sex M / F
Address: _____

Telephone number: Home: _____

Who is filling out this form? _____

With whom does the child live? _____

May we leave messages relating to your child's visits? Yes / No

Emergency contact:

Name: _____ Relation: _____

Address: _____

Home phone: _____ Work Phone: _____

How did you hear about our Clinic: _____

Referred by: _____

Other health care providers (i.e. Medical Doctor, Pediatrician, Chiropractor) the child is seeing:

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

1. _____
2. _____
3. _____
4. _____
5. _____

Medical history

Was this child adopted? Y / N If yes, at what age? _____

Please complete as much of the following information as you know.

Child's Height: _____ Weight: _____ Blood Type: _____

Has your child ever experienced any of the following illnesses (Please Circle)?

- | | | | |
|--------------------------|---------------|-------------------------|-----------------|
| Rubella | Mumps | Measles | Chickenpox |
| Whooping Cough | Scarlet Fever | Polio | Rheumatic fever |
| Diaper rash | Cradle cap | Diarrhea | Constipation |
| High Fevers | Bedwetting | Strep throat | Frequent Colds |
| Stomachaches | Headaches | Gastroesophageal Reflux | |
| Heat or cold intolerance | | | |

Ear infections: How many and how often?

Has your child received any of the following vaccinations (date it was received)?

- | | | | |
|--------|-------|------------|-------|
| DPT | _____ | Flu | _____ |
| MMR | _____ | Smallpox | _____ |
| HiB | _____ | Pneumovax | _____ |
| Polio | _____ | Chickenpox | _____ |
| TB | _____ | | |
| Other: | _____ | | |

Did your child have any adverse reactions or chronic illness following vaccination?

Does your child get regular screening tests done by another doctor? Yes/No

Has your child had any serious conditions, illnesses or injuries, and any hospitalizations?

Please list along with approximate dates.

Does your child have any known allergies (medicines, environmental, etc.)?

Is your child **currently** taking any medications or supplements (prescription, over-the counter, vitamins, herbs, homeopathics, etc.)? Please list.

Prenatal Health and History

Parental History	Blood Type	Health at conception	Health through pregnancy	Age at time of child's birth	# of previous pregnancies
Mother		Poor Fair Good Excellent Unknown	Poor Fair Good Excellent Unknown		
Father		Poor Fair Good Excellent Unknown	Poor Fair Good Excellent Unknown		N/A

Did the mother experience any food cravings/aversions during pregnancy? Y / N

If yes, please list?

Did mother receive medical care during pregnancy? Y / N / Unknown

Did mother experience any of the following during pregnancy (Please circle)?

Bleeding High blood pressure Nausea Physical/emotional trauma
 Vomiting Thyroid problems Diabetes Other _____

Were any of the following interventions used during pregnancy?

Ultrasound Amniocentesis Chorionic villi sampling
 Triple Screen Maternal serum screening
 Other: _____

Did mother use any of the following during pregnancy?

Tobacco Alcohol
 Recreational drugs: _____
 Prescription medications: _____
 Over-the-counter medications: _____
 Vitamins and/or supplements: _____

Birth History

Term length: Pre-term (less than 37 wks): _____ wks
 Full-term (38-42 wks): _____ wks
 Post-term (more than 42 wks): _____ wks

Type of birth: Vaginal or C-section

Interventions:

Induction Use of forceps Epidural/anesthesia Episiotomy

Other: _____

Were there any complications during delivery (e.g., breech)? _____

Length of labour: _____ hrs Weight of infant at birth: _____ kg / lbs

APGAR score, if known (0 to 10):

1 minute _____ 5 minutes _____ 10 minutes _____

Did the child experience any of the following at or shortly after birth?

Jaundice Rashes Seizures

Birth injuries: _____

Infections: _____

Difficulties with feeding: _____

Birth defects: _____

Health and Development

At what age did your child first:

Sit up _____ Crawl _____ Walk _____ Talk _____

At what age did your child begin teething? _____

Were there any difficulties associated with teething? _____

If the child has started their menses, at what age did it begin? _____

Has your child experienced any pubertal changes? _____

Nutritional History

How was your infant fed? Breast fed Formula

How long? _____ Milk/Soy/Other: _____

Did your infant experience any reactions to the breast milk or formula?

What foods were introduced **before 6 months**? Please list the approximate month. Any reactions?

What foods were introduced **between 6 and 12 months**? Were there any reactions to these foods?

Did your child ever experience colic? Y/N If yes, how severely?

Mild / Moderate / Severe

Does your child have any food allergies or intolerances? Please list.

Does your child have any dietary restrictions (vegetarian/vegan, religious, etc.)?

Please describe your child's eating habits (e.g., good appetite, picky eater, etc.).

Does the child have strong aversions to any foods?

Sleep Patterns

What time does your child usually go to bed? _____

Wake in the morning? _____

Does your child nap during the day? Y / N What time(s):

Does your child have nightmares? Y / N How often?

Does your child have any problems associated with sleeping (e.g. trouble falling asleep, grinding teeth, sleep walking, etc.)? _____

Social Patterns

Is your child in: school / daycare / homecare / other: _____

What grade level: _____

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

How about behavior at home? _____

Does your child make friends easily? _____

What are your child's interests & favorite activities? _____

According to your child, does he/she enjoy these activities? _____

Is your child physically active regularly? Y / N

How much & how often? _____

Does your child have any habits (i.e. thumb sucking)? _____

Does your child have any fears? _____

How much television does your child watch? _____ hours/day.

Does your child play on the computer or video games? Y / N

If yes, _____ hrs/wk

How often does your child read (not for school), or How often does someone read to your child? Daily Several times a week Weekly Less than weekly

Environment

Are there any pets in the home? Y / N What type and how many? _____

Does anyone in the child's household smoke? Y / N

How is the child's home heated _____

Are there humidifiers used in your home? _____

How would you describe the emotional climate of the child's home? _____

Has your child ever had any significant physical or emotional traumas?

Please write a little about your child's personality, both positive and negative? Is there anything you would want to change?
