



GREENHOUSE

NATUROPATHIC MEDICINE

Pediatric Intake Form

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.

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

Who are you?

Name: _____

Gender: M F Age: _____ Date of Birth: _____

Parent's Names: _____

Address: _____

Who does the child live with: _____

Phone Number: _____

Emergency Contact: _____ Phone Number: _____

Does the child have a medic alert? _____

Or life threatening allergies? _____

What's going on?

What is the main health concern? _____

What have you had? Check all applicable

<i>Chicken pox</i>	<input type="checkbox"/>	<i>Mononucleosis</i>	<input type="checkbox"/>
<i>Tick Bite</i>	<input type="checkbox"/>	<i>Asthma</i>	<input type="checkbox"/>
<i>Surgery</i>	<input type="checkbox"/>	<i>Allergies</i>	<input type="checkbox"/>

Vaccinations: Check all applicable

<i>D-TaPP (Diphtheria, Pertussis, Tetanus, Polio)</i>	<input type="checkbox"/>	<i>Hib (H. influenza, often given with D-TaP)</i>	<input type="checkbox"/>
<i>MMR (Measles, Mumps, Rubella)</i>	<input type="checkbox"/>	<i>TD + P (Tetanus, Diphtheria, Polio)</i>	<input type="checkbox"/>
<i>OPV</i>	<input type="checkbox"/>	<i>Hepatitis B</i>	<input type="checkbox"/>
<i>Flu shot</i>	<input type="checkbox"/>		<input type="checkbox"/>

Have you ever been to the emergency room? _____

What was it for? _____

What are you taking?

Please list any medications you have taken in the past and the ones you are taking presently. _____

Please list any supplements; vitamins, minerals, herbal medication, homeopathics, that you are currently taking. _____

How was your birth?

During the pregnancy were you exposed to any of the following:

<i>Alcohol</i>		<i>Cigarette smoke</i>	
<i>Recreational drugs</i>		<i>Prescription medications</i>	
<i>Over the Counter drugs</i>		<i>Herbal preparations</i>	
<i>Ultrasound</i>		<i>Amniocentesis</i>	
<i>Illness</i>		<i>Large amount of stress</i>	

Were there any complications during the pregnancy?

<i>Nausea</i>		<i>Hypertension</i>	
<i>Vomiting</i>		<i>Preeclampsia/eclampsia</i>	
<i>Bleeding</i>		<i>Placenta previa</i>	
<i>Gestational diabetes</i>		<i>Maternal rubella</i>	
<i>Maternal chicken pox</i>		<i>Maternal cytomegalovirus</i>	
<i>Maternal toxoplasmosis</i>		<i>Other</i>	

At Birth:

Weight: _____ Length: _____

Were you term? _____ pre-term? _____ post-term? _____ premature? _____

Where did the birth take place? Home Hospital

What type of delivery occurred? Vaginal Cesarean Section

Were there any complications with the birth?

<i>Difficult delivery</i>		<i>Breech delivery</i>	
<i>Long 2nd stage of labor</i>		<i>Shoulder dystocia</i>	
<i>Forceps or suction used</i>		<i>Other</i>	

What were the APGAR scores? _____

Were any interventions administered at birth? Vitamin K Eye drops

What were your mother's feelings about the birth? _____

As a Newborn:

Did you have any of the following conditions?

<i>Jaundice</i>		<i>Colic</i>	
<i>Hip displacement</i>		<i>Meningitis</i>	
<i>Scoliosis</i>			

What do you like to eat?

As a baby were you breastfed? Yes No For how long? _____
Were you fed formula? Yes No
What kind of formula was used? _____
Were there any reactions to the formulas? _____
How old were you when were you introduced to food? _____
What did you eat first? _____
Were there any reactions to any foods? _____

What do you eat now? _____
What are your favorite foods? _____
What foods do you like the least? _____
Do you exclude any foods for religious or ethnic reasons? _____

Where do you live?

What kind of a building do you live in (house, apartment, etc.)? _____
How old is the building? _____
Has it been renovated recently? _____
Does your home have carpet? _____
Has there ever been a problem with mildew in the home? _____

What is your family like?

Has anyone in your family had any of the following diseases? If yes, please indicate who.

<i>Cancer</i>		<i>Diabetes</i>		<i>Heart Disease</i>	
<i>Stroke</i>		<i>Hypothyroidism</i>		<i>Arrhythmia</i>	
<i>Rheumatoid Arthritis</i>		<i>Hyperthyroidism</i>		<i>High blood pressure</i>	
<i>Lupus</i>		<i>Sickle-cell anemia</i>		<i>Crohn's Disease</i>	
<i>An Autoimmune disease</i>		<i>Irritable Bowel Syndrome</i>		<i>Ulcerative Colitis</i>	

What do you like to do?

Do you go to school? Which one? _____
Do you go to daycare? _____
Do you have a nanny? _____
How do you like playing with other kids? _____
Do you have a pet? _____
Do you watch TV? Yes No How often? _____
Do you play video games? Yes No How often? _____
Do you play on the internet? Yes No How often? _____
Do you have family time? Yes No How often? _____
Do you get exercise? Yes No
What do you like to do for exercise? _____
What else do you like to do? _____

How is your sleep?

What position do you like to sleep in? _____

How long do you sleep at night? _____

How long does it take you to fall asleep? _____

Do you wake up during the night? _____

Do you have nightmares? _____

How do you feel when you wake up? _____

Are you rested? _____

Do you take naps? _____

How long are your naps? _____

What is your energy like during the day? _____

From Head to Toe: Please check all that apply.

<i>Cradle cap (seborrheic dermatitis)</i>	<input type="checkbox"/>	<i>ADHD/ ADD</i>	<input type="checkbox"/>
<i>Eczema</i>	<input type="checkbox"/>	<i>Urinary incontinence</i>	<input type="checkbox"/>
<i>Diaper rash</i>	<input type="checkbox"/>	<i>Bedwetting</i>	<input type="checkbox"/>
<i>Yeast infection</i>	<input type="checkbox"/>	<i>Fecal incontinence</i>	<input type="checkbox"/>
<i>Impetigo</i>	<input type="checkbox"/>	<i>Seizures</i>	<input type="checkbox"/>
<i>Conjunctivitis</i>	<input type="checkbox"/>	<i>Paralysis</i>	<input type="checkbox"/>
<i>Scabies</i>	<input type="checkbox"/>	<i>Cerebral Palsy</i>	<input type="checkbox"/>
<i>Sinusitis</i>	<input type="checkbox"/>	<i>Spina bifida</i>	<input type="checkbox"/>
<i>Ear infections</i>	<input type="checkbox"/>	<i>Cystic Fibrosis</i>	<input type="checkbox"/>
<i>Chronic Colds</i>	<input type="checkbox"/>	<i>Chronic Diarrhea</i>	<input type="checkbox"/>
<i>Croup</i>	<input type="checkbox"/>	<i>Appendicitis</i>	<input type="checkbox"/>
<i>Bronchitis</i>	<input type="checkbox"/>	<i>Constipation</i>	<input type="checkbox"/>
<i>Asthma</i>	<input type="checkbox"/>	<i>Chronic Abdominal pain</i>	<input type="checkbox"/>
<i>Pneumonia</i>	<input type="checkbox"/>	<i>Short stature</i>	<input type="checkbox"/>
<i>Cardiovascular problems</i>	<input type="checkbox"/>	<i>Other</i>	<input type="checkbox"/>