Sarah LoBisco, ND
Doctor of Naturopathic Medicine
518-339-4788
Pediatric Intake

CHILDREN'S INTAKE FORM

Child's Name:_____
Age:_____ **Gender:** ☐ **Female** ☐ **Male Date of Birth:**_____/_____/_____
Address: _____
(street address) (city) (province) (postal code)
Telephone: Home_____ **Work**_____**Cell**_____
Email: _____
How did you hear about our office? _____
Emergency Contact:_____
(name) (relationship) (telephone)
Who is your child's family physician?_____
Date of last physical exam:_____

PLEASE COMPLETE THE FOLLOWING QUESTIONS

Please list your current health concerns in order of importance:
1._____
2._____
3._____
4._____
5._____

Please list all medications, over the counter medications, vitamins and supplements your child is currently taking, the dosage and the main reason for taking them:
1._____
2._____
3._____
4._____
5._____

MEDICAL HISTORY **Does your child have any drug allergies?**

1._____
2._____
3._____
List all surgeries your child has had: _____ year? _____
purpose? _____ _____ year? _____
purpose? _____ _____ year? _____
purpose? _____

HEALTH HISTORY **Has your child experienced any of the following conditions?**

Allergies-seasonal **[ ]yes [ ]no** Diarrhea **[ ]yes [ ]no** Allergies-environmental **[ ]yes [ ]no** Difficulty concentrating **[ ]yes [ ]no** Appendicitis **[ ]yes [ ]no** Difficulty sleeping **[ ]yes [ ]no** Atopic dermatitis **[ ]yes [ ]no** Ear infection **[ ]yes [ ]no** Asthma **[ ]yes [ ]no** Eczema **[ ]yes [ ]no** Bronchitis **[ ]yes [ ]no** Frequent colds **[ ]yes [ ]no** Cancer **[ ]yes [ ]no** Hay fever **[ ]yes [ ]no** Chicken pox **[ ]yes [ ]no** Head lice **[ ]yes [ ]no** Chronic bedwetting **[ ]yes [ ]no** Hyperactivity **[ ]yes [ ]no** Chronic nose bleeds **[ ]yes [ ]no** Impetigo **[ ]yes [ ]no** Chronic bruising **[ ]yes [ ]no** Measles **[ ]yes [ ]no** Cold sores **[ ]yes [ ]no** Meningitis **[ ]yes [ ]no** Colic **[ ]yes [ ]no** Mumps **[ ]yes [ ]no** Conjunctivitis (pink eye) **[ ]yes [ ]no** Pneumonia **[ ]yes [ ]no** Constipation **[ ]yes [ ]no** Sinusitis **[ ]yes [ ]no** Convulsions **[ ]yes [ ]no** Skin rash **[ ]yes [ ]no** Cradle cap **[ ]yes [ ]no** Strep throat **[ ]yes [ ]no** Croup **[ ]yes [ ]no** Thrush **[ ]yes [ ]no** Diabetes **[ ]yes [ ]no** Tonsillitis **[ ]yes [ ]no** Diaper rash **[ ]yes [ ]no** Urinary tract infection **[ ]yes [ ]no**

Immunizations, Immune, Birth:

Active Infection (N=never, M=mild, A=average, S=severe)/ How often

___ Rubella (German Measles) x

___ Chicken Pox x

___ Impetigo x

___ Mumps x

___ Colds x

___ Ear Infections x

___ Scarlet Fever x

___ Strept Throat x

___ Measles x

___ Mononucleosis x

___ Roseola x

___ Whooping Cough x

___ Croup x

___ Colic x

Immunizations:

___ DPT (diptheria, pertussis, tetanus)

___Hepatitis A

___Hepatitis B

___ Tetanus booster, when?

___Flu vaccine

___Polio

___ MMR (measles, mumps, rubella)

___Haemophilus influenza B

Reactions? Which ones?

Term length of pregnancy: [ ]pre-term (37 weeks or less):_____weeks [ ]full-term (38-42 weeks):_____weeks [ ]post-term (42 weeks or more):_____weeks Did the infant experience any of the following conditions during or following the birth? [ ]injuries during the birth:_____ [ ]birth defects:_____ [ ]jaundice:_____ [ ]infections:_____

LIFESTYLE

What time does your child go to bed?_____

Wake up?_____

Does your child take naps?_____

When?_____

Do they have any trouble falling asleep?

Do they sleep through the night?_____
Do they wake up well-rested?_____
Do they have any bad dreams or nightmares?_____

How would you describe your child as he/she is presently in terms of personality, general characteristics and any traits that are unique to your child:
_____
_____
Is your child currently in school, daycare, at home?_____

How would you describe your child's behavior in school/daycare _____

Does this differ greatly from behavior at home?_____
What makes your child angry?_____
How does he/she express anger?_____
Do they express their emotions easily?____ _____
Do they experience any uncontrollable emotions (i.e. anger, aggression, crying)?_____
List any significant or traumatic events in your child's life_____
Does your child have any fears?_____

What does your child do when afraid?_____

FOOD INTAKE HISTORY

[ ] Breast fed How long?_____ [ ]easy [ ]difficult

Approximate feeding schedule?_____

[ ] Formula fed How long?_____

What type of formula was used? [ ]milk [ ]soy [ ]goat [ ]other

At what age was solid food first introduced?_____

What types of foods were introduced and in what order?
_____

Did your child have any reactions to foods being introduced?_____ Does your child have any food allergies?_____
_____

Does your child have any dietary restrictions (i.e. religious, vegetarian)?_____

Typical diet:

Breakfast: _____
Lunch: _____

Dinner: _____

Snacks: _____
Beverages: _____
Does your child have any cravings or aversions (please list)?
_____
_____

Does your child avoid certain foods? Why?
_____
_____