EAST BAY
NATUROPATHIC CLINIC
402 Colusa Ave. • El Cerrito, CA 94530 • 510.559.3640

PEDIATRIC INTAKE (Birth to 12 Years)

Child's Name: _____Child's Age: _____
Date of Birth: _____ Grade Level: _____ Gender: _____
Today's Date: _____

Parent/Guardian Contact Information:
Name/relation to child: _____
Address: _____
Home phone: _____ Work or cell phone: _____
Additional parent/guardians:_____
_____

Email Address:_____
Interested in receiving clinic newsletter? Y N

How did you hear about our clinic ?_____
Has any other family member been a patient at the clinic? _____

Please list child's current health care providers with their designation (family doctor, pediatrician, etc) and contact information:
_____
_____
_____

Health Concerns:
What is the reason for today's visit?

Are there other health problems or concerns?

Medications and Supplements:
Does your child have any allergies to medications? No Yes:_____
Current medications:
_____
_____
Past medications:
_____
_____
How many times has your child had antibiotics? _____

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Current herbs, supplements, vitamins or homeopathic remedies given:

_____

_____

_____

Past Medical History:

Please mark any conditions your child has had in the past:

- ☐ Chicken Pox
- ☐ Whooping Cough
- ☐ Measles
- ☐ Mumps
- ☐ Rubella
- ☐ Ear Infections
- ☐ Cold Sores
- ☐ Strep Throat
- ☐ Mononucleosis
- ☐ Pneumonia
- ☐ Head Injury
- ☐ Seizures
- ☐ Meningitis
- ☐ Colic
- ☐ Allergies
- ☐ Asthma
- ☐ Eczema
- ☐ Impetigo
- ☐ Urinary Tract Infection
- ☐ Other, please list:

_____

Has your child had any serious illnesses, injuries, surgeries, or hospitalizations? If yes, please list and include dates:

_____

_____

_____

Has your child had any of the following? If yes, please list when, where and the results:

Psychological Evaluation

_____

Hearing Test

_____

Speech/Language Test

_____

Immunizations (Please mark which immunizations your child has received):

- ☐ Measles
- ☐ Mumps
- ☐ Rubella
- ☐ Diptheria
- ☐ Tetnus
- ☐ Pertussis
- ☐ Polio
- ☐ Chicken Pox
- ☐ Hep B
- ☐ Hep A
- ☐ Rotavirus
- ☐ Flu
- ☐ H. Influenza
- ☐ Meningococcal
- ☐ Pneumococcal
- ☐ HPV

Any adverse reactions? No Yes:_____

At what age did your child begin: Sitting____ Crawling____ Walking ____ Talking____

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Family History:
Do any family members including grandparents, parents, and siblings have any of the following conditions:

- ☐ Heart Disease
- ☐ Stroke
- ☐ Hypertension
- ☐ Cancer
- ☐ Diabetes
- ☐ Mental Illness
- ☐ Arthritis
- ☐ Allergies
- ☐ Asthma
- ☐ Eczema
- ☐ Celiac
- ☐ Genetic Disorder

Please list any other relevant family history:
_____
_____

Prenatal History:
Mother's age at birth: _____ Mother's health during pregnancy:_____
Please mark any of the following experienced during pregnancy:

- ☐ Anemia
- ☐ Nausea
- ☐ Infection
- ☐ Hypertension
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Depression
- ☐ Cigarette, Alcohol, or Drug Consumption
- ☐ Physical or Emotion Trauma

Please list any other complications during pregnancy: _____
Please list any medications used during pregnancy: _____

Birth History:
Term: ☐ Preterm (37 weeks or less) ☐ Full (38-42weeks) ☐ Post-term (42 weeks)
Was labor induced? _____ Length of Labor: _____ hours
Type of Delivery: ☐ Vaginal ☐ Caesarian ☐ Assisted Delivery (forceps, vacuum)
Were there any complications during or shortly after birth? If yes, please describe:
_____
_____
Birth Weight: _____ Length at Birth: _____ APGARS: _____

Diet History:
Was your child breastfed? _____ For how long?_____
Was formula given? _____ For how long?_____
If given formula, what type was used (milk, soy, other)? _____
Age began solid foods? What foods were introduced and in what order?
_____
Does your child have any food allergies or intolerances?_____
Food likes: _____
Food dislikes: _____

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Please describe your child's typical daily diet:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Drinks: _____
Any dietary restrictions (religious, vegetarian, etc)?
_____

Lifestyle:
Current sleep patterns?
_____
Does your child exercise regularly? What type?
_____
What are your child's favorite hobbies, activities?
_____
How would you describe your child's temperament?
_____
How would you describe your child's behavior and performance at school?
_____
Does your child have any siblings? If yes, how many and what ages?
_____
Please list any stressors for your child (social, academic, family, etc.)?
_____

Symptoms:
Does your child have any of the following symptoms?

- ☐ Headaches
- ☐ Impaired Vision
- ☐ Hearing Loss
- ☐ Runny Nose
- ☐ Sneezing
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Sore Throat
- ☐ Swollen Tonsils
- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Tooth Defects
- ☐ Canker Sores
- ☐ Cough
- ☐ Wheezing
- ☐ Heart Murmur
- ☐ Bruises Easily
- ☐ Anemia
- ☐ Rash
- ☐ Acne
- ☐ Hives
- ☐ Skin Growths
- ☐ Yellowing of Skin
- ☐ Stomachaches
- ☐ Diarrhea
- ☐ Constipation
- ☐ Distended Abdomen
- ☐ Change in Appetite
- ☐ Reflux
- ☐ Colic
- ☐ Bedwetting
- ☐ Pain on Urination
- ☐ Frequent Urination
- ☐ Muscle aches
- ☐ Joint Pain
- ☐ Swelling of Joints
- ☐ Frequent Colds
- ☐ Poor Wound Healing
- ☐ Cries Easily
- ☐ Irritability
- ☐ Fatigue

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- ☐ Nightmares
- ☐ Unusual Fears
- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty Concentrating
- ☐ Hyperactive
- ☐ Other, please list:

Thank you for your time and effort. We look forward to helping your child in any way we can. Bring this form to your first visit or fax it beforehand to 510-559-3224. Please use the rest of this page to list additional information.