

**Trillium Natural Medicine**  
 Naturopathic Medicine & Acupuncture  
 3043 West Liberty Ave.  
 Pittsburgh, PA 15216  
 (412) 571-9355

**PEDIATRIC INTAKE FORM (Birth- 5 years)**

***Personal Information***

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

Sex:                      Male:                       Female:

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone # (home): \_\_\_\_\_ (work): \_\_\_\_\_

Parent's e-mail address: \_\_\_\_\_

Name of Dr.'s Office/Hospital/Clinic where your child's health records are kept: \_\_\_\_\_

How did you hear about our clinic?  
 \_\_\_\_\_

<b><i>Medications</i></b>	<b>Now</b>	<b>Past</b>		<b>Now</b>	<b>Past</b>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Tylenol	<input type="checkbox"/>	<input type="checkbox"/>	Antihistamine	<input type="checkbox"/>	<input type="checkbox"/>
Decongestant	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Ibuprofin	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to medicines		

***Health History Questionnaire***

What are your child's most important health problems? List as many as you can in order of importance:

1. \_\_\_\_\_

2.

3.

4.

5.

Does your child have a contagious disease at this time?

Y  N

If yes, what?

Rheumatic fever

Y  N

German measles

Y  N

Chicken pox

Y  N

Measles

Y  N

Mumps

Y  N

Rubella

Y  N

Tonsillitis

Y  N

Scarlet fever

Y  N

Pneumonia

Y  N

Frequent colds

Y  N

Ear infections

Y  N

approx. number

Other (Please list)

***Hospitalizations/ Surgeries/ Injuries***

Has your child had any of the following tests?

When

Where

Electroencephalogram (EEG)

Y  N

Psychological evaluation

Y  N

Hearing tests

Y  N

Speech/Language tests

Y  N

What hospitalizations, surgeries or injuries has your child had?

***Immunizations***

Polio

Y  N

Pertussis

Y  N

Tetanus shot

Y  N

Diphtheria

Y  N

Measles

Y  N

MMR

Y  N

Mumps

Y  N

Smallpox

Y  N

DPT

Y  N

Influenza

Y  N

Any adverse reactions

Y  N

If yes, what

**Allergies**

Is your child hypersensitive or allergic to:

Which (if yes):

Any drugs/medications? Y  N Any foods? Y  N Any environmental? Y  N 

Breast fed? how long Formula milk / soy

**Family History**Heart disease  Diabetes  Birth defects Hypertension  Arthritis  Tuberculosis Cancer  Allergies  Mental illness **Prenatal History**

Previous pregnancies by natural mother, miscarriage or complications?

Mother's age at child's birth? \_\_\_\_\_

Mother's health during pregnancy? \_\_\_\_\_

Heart disease  Diabetes  Birth defects Hypertension  Arthritis  Tuberculosis Cancer  Allergies  Mental illness **Birth History**Term Full  Premature  Late  Weeks: \_\_\_\_\_

Length of labor \_\_\_\_\_ Complications \_\_\_\_\_ Birth weight: \_\_\_\_\_

Did your child have any of the following problems shortly after birth?

Birth defects  Birth injuries  Blue baby Cerebral Palsy  Seizures  Jaundice Colic  Fever  Rashes 

Other (explain) \_\_\_\_\_

Child's sleep patterns (first year) \_\_\_\_\_

Food intolerances (if any) \_\_\_\_\_

Feeding: Breast fed \_\_\_\_\_ How long? \_\_\_\_\_ Formula? \_\_\_\_\_ Milk/soy \_\_\_\_\_

Age began solids

Which types of food?

Age began:

Sitting

Crawling

Walking

Talking

**Diet**

Please describe you child's typical daily diet

Breakfast

Lunch

Dinner

Snacks

To drink

Y= current condition	P= significant problem in past
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**Review of Symptoms**

Hives	Y <input type="checkbox"/>	P <input type="checkbox"/>	Frequent urination	Y <input type="checkbox"/>	P <input type="checkbox"/>
Eczema	Y <input type="checkbox"/>	P <input type="checkbox"/>	Heart murmur	Y <input type="checkbox"/>	P <input type="checkbox"/>
Bleeding gums	Y <input type="checkbox"/>	P <input type="checkbox"/>	Vomiting spells	Y <input type="checkbox"/>	P <input type="checkbox"/>
Nose bleeds	Y <input type="checkbox"/>	P <input type="checkbox"/>	Anemia	Y <input type="checkbox"/>	P <input type="checkbox"/>
Acne	Y <input type="checkbox"/>	P <input type="checkbox"/>	Stomach aches	Y <input type="checkbox"/>	P <input type="checkbox"/>
High fevers	Y <input type="checkbox"/>	P <input type="checkbox"/>	Jaundice	Y <input type="checkbox"/>	P <input type="checkbox"/>
Chronic rash	Y <input type="checkbox"/>	P <input type="checkbox"/>	Easy bruising	Y <input type="checkbox"/>	P <input type="checkbox"/>
Hearing loss	Y <input type="checkbox"/>	P <input type="checkbox"/>	Flat feet	Y <input type="checkbox"/>	P <input type="checkbox"/>
Diarrhea	Y <input type="checkbox"/>	P <input type="checkbox"/>	Constipation	Y <input type="checkbox"/>	P <input type="checkbox"/>
Sore throats	Y <input type="checkbox"/>	P <input type="checkbox"/>	Gas	Y <input type="checkbox"/>	P <input type="checkbox"/>
Headaches	Y <input type="checkbox"/>	P <input type="checkbox"/>	Bleeding tendency	Y <input type="checkbox"/>	P <input type="checkbox"/>
Frequent colds	Y <input type="checkbox"/>	P <input type="checkbox"/>	Joint pains	Y <input type="checkbox"/>	P <input type="checkbox"/>
Wheezing	Y <input type="checkbox"/>	P <input type="checkbox"/>	Dizzy spells	Y <input type="checkbox"/>	P <input type="checkbox"/>
Cough	Y <input type="checkbox"/>	P <input type="checkbox"/>	Bloody uring	Y <input type="checkbox"/>	P <input type="checkbox"/>
Burning of urine	Y <input type="checkbox"/>	P <input type="checkbox"/>	Cries easily	Y <input type="checkbox"/>	P <input type="checkbox"/>
Nervous	Y <input type="checkbox"/>	P <input type="checkbox"/>	Sleep problems	Y <input type="checkbox"/>	P <input type="checkbox"/>
Light sensitivity	Y <input type="checkbox"/>	P <input type="checkbox"/>	Night sweats	Y <input type="checkbox"/>	P <input type="checkbox"/>
Body/breath odor	Y <input type="checkbox"/>	P <input type="checkbox"/>	Night sweats	Y <input type="checkbox"/>	P <input type="checkbox"/>
Motion/car sickness	Y <input type="checkbox"/>	P <input type="checkbox"/>	No appetite	Y <input type="checkbox"/>	P <input type="checkbox"/>

Nightmares	Y <input type="checkbox"/>	P <input type="checkbox"/>	Canker sores	Y <input type="checkbox"/>	P <input type="checkbox"/>
Unusual fears	Y <input type="checkbox"/>	P <input type="checkbox"/>	Excessive fatigue	Y <input type="checkbox"/>	P <input type="checkbox"/>
Excessive fatigue	Y <input type="checkbox"/>	P <input type="checkbox"/>	Hair loss	Y <input type="checkbox"/>	P <input type="checkbox"/>

Is there any information about your child's health that you would like to add?

What expectations do you have for your child from working with our clinic?

Thank you for taking the time to fill out this form.  
I look forward to helping your child in any way I can.