trillium
NATURAL MEDICINE
naturopathic medicine & acupuncture

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PEDIATRIC INTAKE FORM (Birth–5 years)

Patient's name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian's name: _____

Telephone # (home): _____ Parent's # (work): _____

Parent's email address: _____

Age: _____ Date of Birth: _____ Gender: ❑ Female ❑ Male

How did you hear about Trillium Natural Medicine? _____

Has any other family member already been a patient at Trillium Natural Medicine? _____

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

_____

Reason for referral or presenting problems: _____

_____

Does your child have a contagious disease at this time? ❑ Yes ❑ No

If yes, what? _____

Medications

Aspirin ❑ Now ❑ Past Ibuprofin ❑ Now ❑ Past Others ❑ Now ❑ Past (please list)____

Tylenol ❑ Now ❑ Past Antibiotics ❑ Now ❑ Past _____

Decongestant ❑ Now ❑ Past Anti-histamine ❑ Now ❑ Past Allergies to Medicine _____

Please list **any** prescription medications, over the counter medications, vitamins or other supplements your child is taking:

1. _____ 3. _____

2. _____ 4. _____

Medical History

❑ Chicken pox ❑ Scarlet fever ❑ Tonsillitis, approx. no. _____

❑ Measles ❑ Pneumonia ❑ Ear Infections, no. _____

❑ Mumps ❑ Frequent colds ❑ Other (please list) _____

❑ Rubella ❑ Rheumatic fever _____

Injuries/Surgeries/Hospitalizations (please list): _____

_____

Has your child had any of the following tests? When Where Results

Electroencephalogram _____

Psychological evaluation _____

Hearing _____

Speech/Language _____

Immunizations

❑ MMR ❑ DPT ❑ Chicken Pox ❑ Hepatitis ❑ Measles ❑ Diptheria ❑ Small Pox

❑ Mumps ❑ Tetanus ❑ H. influenza ❑ Rubella ❑ Polio ❑ The Flu ❑ Pertussis

Others (please list): _____

_____

Any adverse reactions? ❑ Yes ❑ No If yes, what? _____

Family History

Do you have a family history of any of the following (please check)?

❑ Asthma/Hayfever/Hives ❑ Alzheimer's ❑ Cancer ❑ Diabetes

❑ Epilepsy Arthritis ❑ Heart Disease ❑ High Blood Pressure ❑ Glaucoma

❑ Kidney Disease ❑ Mental Illness ❑ Stroke Anemia ❑ Tuberculosis

Any other relevant family history? _____

_____

What is your heritage? (for identifying risk factors for disease) _____

Prenatal History

Previous pregnancies by natural mother, miscarriages, or complications? _____

_____

Mother's age at child's birth? _____

Mother's health during pregnancy?

❑ Bleeding ❑ Physical or emotional trauma ❑ Nausea

❑ Illnesses ❑ Medications ❑ Cigarettes, alcohol, drug consumption

❑ Hypertension ❑ Thyroid problems ❑ Diabetes

Birth History

Term: ❑ Full ❑ Premature ❑ Late Length of Labor: _____ Complications? _____

Birth city & state: _____ Birth time: _____ 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): _____

Breast fed? ❑ Yes ❑ No How long? _____ Formula? ❑ Yes ❑ No Type (milk /soy) other _____

Age began solids: _____ Which foods? _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

For the Following, Please Check the Appropriate Response Based on the Key Below:

Y=a condition your child has now **N**=Never had **P**=Significant problem in the past

Hives? ❑ Y ❑ N ❑ P
Bloody urine? ❑ Y ❑ N ❑ P
Frequent urination? ❑ Y ❑ N ❑ P
Bleeding gums? ❑ Y ❑ N ❑ P
Nervous? ❑ Y ❑ N ❑ P
Vomiting spells? ❑ Y ❑ N ❑ P
Acne? ❑ Y ❑ N ❑ P
Night sweats? ❑ Y ❑ N ❑ P
Stomach aches? ❑ Y ❑ N ❑ P
Chronic rash? ❑ Y ❑ N ❑ P
Body/breath odor? ❑ Y ❑ N ❑ P
Easy bruising? ❑ Y ❑ N ❑ P
Diarrhea? ❑ Y ❑ N ❑ P
No appetite? ❑ Y ❑ N ❑ P
Constipation? ❑ Y ❑ N ❑ P
Headaches? ❑ Y ❑ N ❑ P
Canker sores? ❑ Y ❑ N ❑ P
Bleeding tendency? ❑ Y ❑ N ❑ P
Wheezing? ❑ Y ❑ N ❑ P
Excessive fatigue? ❑ Y ❑ N ❑ P
Dizzy spells? ❑ Y ❑ N ❑ P

Burning of urine? ❑ Y ❑ N ❑ P
Eczema? ❑ Y ❑ N ❑ P
Cries easily? ❑ Y ❑ N ❑ P
Heart murmur? ❑ Y ❑ N ❑ P
Nose bleeds? ❑ Y ❑ N ❑ P
Sleep problems? ❑ Y ❑ N ❑ P
Anemia? ❑ Y ❑ N ❑ P
High fevers? ❑ Y ❑ N ❑ P
Sensitive to light? ❑ Y ❑ N ❑ P
Jaundice? ❑ Y ❑ N ❑ P
Hearing loss? ❑ Y ❑ N ❑ P
Motion/car sickness? ❑ Y ❑ N ❑ P
Flat feet? ❑ Y ❑ N ❑ P
Sore throats? ❑ Y ❑ N ❑ P
Nightmares? ❑ Y ❑ N ❑ P
Gas? ❑ Y ❑ N ❑ P
Frequent colds? ❑ Y ❑ N ❑ P
Unusual fears? ❑ Y ❑ N ❑ P
Joint pains? ❑ Y ❑ N ❑ P
Cough? ❑ Y ❑ N ❑ P
Hair loss? ❑ Y ❑ N ❑ P

Diet

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Is there anything else you would like to add or comment on?

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

Thank you. We look forward to helping your child in any way we can.