trillium
NATURAL MEDICINE
naturopathic medicine & acupuncture

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PEDIATRIC INTAKE FORM (6–12 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: _____

_____

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

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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

If yes, what? _____

Medications

Aspirin ❑ Now ❑ Past Ibuprofin ❑ Now ❑ Past Tylenol ❑ Now ❑ Past

Antibiotics ❑ Now ❑ Past Decongestant ❑ Now ❑ Past Anti-histamine ❑ Now ❑ Past

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

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

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) _____

Allergies

Is your child hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmentals or chemicals? _____

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

Diet

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

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

Review of Systems

Mental / Emotional

Mood Swings? ❑ Y ❑ N ❑ P
Irritability? ❑ Y ❑ N ❑ P
Hyperactivity? ❑ Y ❑ N ❑ P
Introvert/extrovert? ❑ Y ❑ N ❑ P
Motion/car sickness? ❑ Y ❑ N ❑ P
Anxiety/nervousness? ❑ Y ❑ N ❑ P
Cries easily? ❑ Y ❑ N ❑ P
Unusual fears? ❑ Y ❑ N ❑ P
Sleep problems? ❑ Y ❑ N ❑ P
Nightmares? ❑ Y ❑ N ❑ P

Endocrine

Heat/cold intolerance? ❑ Y ❑ N ❑ P
Excessive thirst? ❑ Y ❑ N ❑ P
Low blood sugar? ❑ Y ❑ N ❑ P
Fatigue? ❑ Y ❑ N ❑ P
Excessive hunger? ❑ Y ❑ N ❑ P
High blood sugar? ❑ Y ❑ N ❑ P

Skin

Rashes? ❑ Y ❑ N ❑ P
Acne, Boils? ❑ Y ❑ N ❑ P
Eczema, Hives? ❑ Y ❑ N ❑ P
Itching? ❑ Y ❑ N ❑ P

Head

Headaches? ❑ Y ❑ N ❑ P
Dizzy Spells? ❑ Y ❑ N ❑ P
Head Injury? ❑ Y ❑ N ❑ P
High fevers? ❑ Y ❑ N ❑ P

Eyes

Glasses or contacts? ❑ Y ❑ N ❑ P
Blurriness? ❑ Y ❑ N ❑ P
Tearing or dryness? ❑ Y ❑ N ❑ P
Eye pain/strain? ❑ Y ❑ N ❑ P

Ears

Impaired hearing? ❑ Y ❑ N ❑ P
Earaches? ❑ Y ❑ N ❑ P

Nose and Sinuses

Frequent colds? ❑ Y ❑ N ❑ P
Stuffiness? ❑ Y ❑ N ❑ P
Sinus problems? ❑ Y ❑ N ❑ P
Nose Bleeds? ❑ Y ❑ N ❑ P
Hayfever? ❑ Y ❑ N ❑ P
Loss of smell? ❑ Y ❑ N ❑ P

Mouth and Throat

Frequent sore throat? ❑ Y ❑ N ❑ P
Teeth grinding? ❑ Y ❑ N ❑ P
Canker Sores? ❑ Y ❑ N ❑ P
Breath Odor? ❑ Y ❑ N ❑ P

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

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Respiratory

Cough? ❑ Y ❑ N ❑ P
Wheezing? ❑ Y ❑ N ❑ P
Asthma? ❑ Y ❑ N ❑ P
Bronchitis? ❑ Y ❑ N ❑ P

Cardiovascular

Heart disease? ❑ Y ❑ N ❑ P
Murmurs? ❑ Y ❑ N ❑ P

Gastrointestinal

Belching or passing gas? ❑ Y ❑ N ❑ P
Stomach aches? ❑ Y ❑ N ❑ P
Constipation? ❑ Y ❑ N ❑ P
Diarrhea? ❑ Y ❑ N ❑ P

Bowel Movements: How often? _____

Urinary

Pain on urination? ❑ Y ❑ N ❑ P
Increased frequency? ❑ Y ❑ N ❑ P
Frequency at night? ❑ Y ❑ N ❑ P
Inability to hold urine? ❑ Y ❑ N ❑ P
Frequent infections? ❑ Y ❑ N ❑ P
Kidney stones? ❑ Y ❑ N ❑ P

Musculoskeletal

Joint pain or stiffness? ❑ Y ❑ N ❑ P
Arthritis? ❑ Y ❑ N ❑ P
Broken bones? ❑ Y ❑ N ❑ P
Weakness? ❑ Y ❑ N ❑ P
Muscle spasms or cramps? ❑ Y ❑ N ❑ P
Sciatica? ❑ Y ❑ N ❑ P

Blood / Peripheral Vascular

Easy bleeding or bruising? ❑ Y ❑ N ❑ P
Anemia? ❑ Y ❑ N ❑ P
Deep leg pain? ❑ Y ❑ N ❑ P
Cold hands/feet? ❑ Y ❑ N ❑ P
Varicose veins? ❑ Y ❑ N ❑ P
Thrombophlebitis? ❑ Y ❑ N ❑ P

Musculoskeletal

Joint pain/stiffness? ❑ Y ❑ N ❑ P
Muscle spasms/cramps? ❑ Y ❑ N ❑ P
Broken bones? ❑ Y ❑ N ❑ P

Blood/Peripheral Vascular

Anemia? ❑ Y ❑ N ❑ P
Easy bleeding/bruising? ❑ Y ❑ N ❑ P

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.