

Athens Natural Medicine
Martha Allen, ND, LAc
Naturopathic and Chinese medicine

Pediatric intake form

patient's name: _____ date: _____

address: _____

city: _____ state: _____ zip: _____

telephone (home): _____ cell: _____

parents work phone: _____ email _____

age: _____ date of birth: _____ gender: female / male

how did you hear about this clinic? _____

name of
pediatrician _____ phone: _____

most important health concerns:

1) _____

2) _____

3) _____

4) _____

medications (please circle)

aspirin decongestants antibiotics

tylenol antihistamine ibuprofen

other, including natural supplements: _____

allergies to medications: _____

environmental allergies: _____

food allergies: _____

medical history (please circle)

chicken pox

scarlet fever

tonsillitis

frequent colds

measles

pneumonia

ear infections

rheumatic fever

mumps

rubella

strep throat

other: _____

family history

is there a family history of any of the following? (please circle)

heart disease

diabetes

birth defects

allergies

hypertension

arthritis

tuberculosis

asthma

mental illness

osteoporosis

cancer

other: _____

immunizations

___mmr

___dpt

___chicken pox

___small pox

___measles

___diphtheria

___h.influenza

___hepatitis b

___mumps

___tetanus

___rubella

___polio

others: _____

adverse reactions: yes / no

has your child ever had any of the following? when? results?

electroencephalogram (eeg): _____

psychological evaluations: _____

hearing test: _____

speech/language tests: _____

injuries/ surgeries/ hospitalizations: _____

prenatal history

mother's age at child's birth: _____

mother's health during pregnancy:

_____ bleeding _____ nausea _____ +physical or emotional trauma

_____ illnesses _____ hypertension _____ cigarettes, alcohol, drug consumption

_____ medications _____ diabetes _____ thyroid problems

birth history

term: full / premature / late length of labor: _____

_____ vaginal birth or _____ c- section

any complications?

did your child have any of the following problems shortly after birth? (please circle)

rashes birth injuries blue baby colic birth defects

jaundice seizures cerebral palsy fever

other: _____

breast fed: y / n how long? _____ formula? y / n

type: cow's milk / soy / other _____

has your child experienced any of the following: (please circle)

hives	burning urine	bloody urine	eczema
bleeding gums	heart murmur	nervousness	hair loss
nose bleeds	vomiting spells	sleep problems	asthma
acne	anemia	night sweats	high fevers
jaundice	sensitivity to light	chronic rashes	sore throats
diarrhea	hearing loss	easy bruising	cough
flat feet	loss of appetite	body/breath odor	constipation
allergies	stomach aches	unusual fears	excessive fatigue
nightmares	frequent colds	bleeding tendency	frequent urination
wheezing	joint pains	dizzy spells	

please describe your child's typical daily diet:

breakfast: _____

snack: _____

lunch: _____

snack: _____

dinner: _____

drinks: _____

sleep:

bed time: _____

wake time: _____

number of naps: _____