ATHENS NATURAL MEDICINE

Naturopathic Medicine and Acupuncture

Pediatric Intake Form Confidential

Dr. Martha E. Allen, ND, LAc, MSOM The Leather's Building
675 Pulaski Street Suite 1300 Athens, GA 30601
phone: 706-850-2512 email: aim@drmarthaallen.com

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 office?____

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:_________