BAINBRIDGE Natural Health

PEDIATRIC INTAKE

Patient:_____ **Date of Birth**_____/_____/_____**Age**_____

Name of primary care physician or pediatrician:

Doctor's Name:_____**Phone:**_____

Location/ Clinic:_____**City/ State/ Zip**_____

REASON FOR VISIT

_____

_____

Has your child seen any other providers for this reason? If yes, who and what was the outcome?

_____

_____

MEDICATIONS AND SUPPLEMENTS

List current medications, include dosage and prescribing doctor's name:

_____

_____

List current supplements, include brand, dosage, and reason for taking:

_____

_____

Does your child have any ALLERGIES (drugs, bees, foods, etc)? Please list, and describe reaction:

_____

_____

MEDICAL HISTORY

____ Chicken pox	____ Eczema	____ Tonsillitis, # of times:____
____ Measles	____ Pneumonia	____ Strep throat, # of times:____
____ Mumps	____ Frequent Colds	____ Ear infections, # of times:____
____ Rubella	____ Asthma	____ Rheumatic Fever
____ Scarlet Fever	____ Pertussis/ Whooping Cough	____ Antibiotic use, # of times:____

Other serious illnesses?_____

_____

Has your child had any of the following? Please include when, where, and results.

Electroencephalogram(EEG):_____PsychologicalEvaluation:_____

Hearing Test:_____Speech/ Language Test:_____

Injuries/ Surgeries/ Hospitalizations (please list):_____

_____

_____

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IMMUNIZATIONS

____ Up-to-date on all recommended vaccinations

____ None-to-date

Vaccinations given:_____

_____

FAMILY HISTORY

____ Heart Disease ____ Diabetes ____ Birth Defects ____ Cancer

____ Hypertension ____ Asthma ____ Arthritis ____ Tuberculosis

____ Mental Illness ____ Osteoporosis ____ Allergies ____ Epilepsy

Others:_____

PRENATAL HISTORY

Mother's age at child's birth ____ and health during pregnancy:

____ Bleeding ____ Nausea ____ Physical or emotional trauma

____ Illnesses ____ Hypertension ____ Cigarettes, alcohol, drug use

____ Medications ____ Diabetes ____ Thyroid problems

Other:_____

BIRTH HISTORY

Term: ____ Full ____ Late ____ Premature Weight at birth:_____lbs_____oz Length:_____inches

Length of labor:_____ Complications:_____

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

____ Rashes ____ Jaundice ____ Colic ____ Birth Injuries

____ Blue Baby ____ Seizures ____ Fever ____ Cerebral Palsy

____ Birth Defects

Other:_____

DIET

Please describe your child's typical daily diet, including snacks and beverages:_____

_____

_____

Is there anything else that you would like the physician to know about your child or your child's healthcare needs?

_____

_____

_____

_____

_____

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