Lilac Natural Medicine

Pediatric Intake Form **Today's Date_____**

Name:_____ Preferred Name:_____

Date of Birth: _____ Age: _____ Gender: M or F or Transgender

Grade in School:_____ Name of School: _____

Street Address: _____ City:_____

State:_____ Zip:_____ Email Address: _____

Home phone: _____ Work Phone: _____ Cell Phone: _____

Social Security Number: _____ Number of Siblings: _____

Parent's Name and occupation: _____

Parent's Name and occupation: _____

Parents are (circle): Married Separated Divorced Living Together Other

Reason for today's Office Visit:_____

Has the child been seen by any other practitioner for this complaint? Yes No Past

If Yes, where and by whom? _____

How did you hear about us? _____ Has the child had any blood work done? Y / N

Pediatrician / PCP: _____ Has the child ever been seen by a Naturopathic Physician? Y / N

List any surgeries or hospitalizations and year occurred:

1.
2.
3.

List all medications (OTC and prescription) the child is currently taking ***(please bring the bottles to your visit)***:

1.
2.
3.

List all vitamins and supplements the child is currently taking ***(please bring the bottles to your visit)***:

1.
2.
3.

Any known Allergies to food, drugs, environment, animals and their reaction (*e.g. peanuts causes hives*):

_____

_____

_____

Past Medical History:

Yes indicates the child gets the problem regularly; **No** indicates the child never had the problem; **P**ast indicates the child had the problem in the past but not recently.

Ear Infections?	Yes	No	Past	If has had, how many total? _____
Colds?	Yes	No	Past	If has had, how many total? _____
Strep throat?	Yes	No	Past	If has had, how many total? _____

How many times has the child taken antibiotics:_____

What other medicines has the child taken? And how often?

1.

2.

3.

4.

Hearing Tests Normal:	Yes	No	Not Tested
Vision Tests Normal:	Yes	No	Not Tested
Any Speech Impediments:	Yes	No	Past
Learning Impediments:	Yes	No	Don't know

Vaccination History: **Yes**, has had; No, has not; **Some**, did not finish all shots

MMR:	Yes	No	Some	DTaP:	Yes	No	Some
Hep B:	Yes	No	Some	Hib:	Yes	No	Some
Chickenpox:	Yes	No	Some	Polio:	Yes	No	Some
Pneumococcal:	Yes	No	Some	Other:_____			

Any reactions to vaccinations? If so, please explain: _____

_____

Family History:

Allergies:	Yes	No	Obesity:	Yes	No
Cancer:	Yes	No	Cardiovascular disease:	Yes	No
Mental Illness:	Yes	No	Diabetes mellitus:	Yes	No

Mother's Pregnancy History

Age at conception:_____

Did she have other children already? Yes No

Smoking:	Yes	No	Gestational Diabetes:	Yes	No
Coffee:	Yes	No	Nausea/Vomiting:	Yes	No
Recreational drugs:	Yes	No	Emotional Stress:	Yes	No
Preeclampsia:	Yes	No	Length of Labor:	_____	
Vaginal birth:	Yes	No	Traumatic birth:	Yes	No

If the birth was difficult, please explain: _____

Past Medical History:

Child's birth weight: :_____

Health of baby at birth:_____

Child breastfed: Yes No For how long:_____

When put on formula:_____ What formula was used:_____

When was child put on solid food:_____

When did child walk:_____ Talk:_____

When did child develop teeth:_____

Jaundice as baby:	Y / N / Past	Colic:	Y / N / Past
Cradle cap:	Y / N / Past	Anemia:	Y / N / Past
Eczema or Psoriasis:	Y / N / Past	Asthma:	Y / N / Past
Diarrhea:	Y / N / Past	Constipation:	Y / N / Past
Nightmares:	Y / N / Past	Diaper Rash:	Y / N / Past
Finicky eating:	Y / N / Past	Bed-wetting:	Y / N / Past
Poor teeth:	Y / N / Past	Tantrums:	Y / N / Past
Chronic sniffles:	Y / N / Past	Disobedient:	Y / N / Past
Bad foot odor:	Y / N / Past	Fears/Phobia:	Y / N / Past
Hyperactivity:	Y / N / Past	Early Puberty:	Y / N / Past
Growing pains:	Y / N / Past	Stomach aches:	Y / N / Past

How many bowel movements per day? _____ Hours of sleep per night? _____

Last Dental Visit: _____ Cavities? Y / N / Past

List any household stressors the child has witnessed or gone through:

1._____

2._____

Diet:

Please list foods that your child currently eats:

Meat:	Fruit:	Veg:	Grain:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Other: _____	_____	_____	_____

Typical Day's Diet:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Beverages:_____

Safety:

Seat Belts Used? Y / N Car Seat Used? Y / N

Are there weapons in the home? Y / N If Yes, are they locked up? Y / N

Secondhand smoke exposure? Y / N / Previous

Toxin Exposure:

Has the child ever:

Lived near a refinery or highly polluted area? Y / N

Lived in a house with lead paint? Y / N

Lived in a house with new paint, cabinets, carpeting, etc? Y / N

Do you spray pesticides or herbicides around the house or use other toxic chemicals? Y / N

Does the child seem particularly sensitive to perfumes or other vapors? Y / N