Collaborative Natural Health Partners

NEW PEDIATRIC PATIENT INTAKE

Please note that patients must be accompanied at every visit by an adult who is allowed to make medical decisions on their behalf.

Name _____ Gender _____ Date of Birth _____ Age ____
Address _____ City _____ State ____ Zip _____

Home _____ Cell _____ Work _____
What is your preferred number? C H W Can we leave messages on this voicemail? Y N

Who do we have permission to discuss your child's care with? _____
Parent's Occupation _____ Employer_____
Email Address _____Preferred Pharmacy _____

Insurance:
Subscriber's name _____Relationship_____
Insurance Carrier_____ Subscriber's phone number _____
Subscriber's address (if different) _____
Subscriber's date of birth _____

List of providers (e.g. primary care physician, oncologist, therapist, rheumatologist)

Name/Group Location Phone number
_____
_____
_____
_____

Are you transferring for primary care? __ Yes __ No
Please note that we cannot be primary care for under age 12 at this time. Naturopathic physicians are not primary care physicians in the state of Connecticut.

Emergency Contact:

Name (Relation)_____Phone_____

Family Information:

Parental Marital Status: Single Married Partner Divorced Widow(er)
Who can make medical decisions and have access to medical records?
Mother Father Other: _____
Siblings: Y N Number_____ Age(s) _____
Additional family members living in the home: _____

Does the child attend: Daycare School Other: _____

How did you hear about our practice?

_____

Present Health Concerns (in order of importance):

1. _____
2. _____
3. _____
4. _____

Current Medications (including O-T-C):

Name of Drug	Reason for taking	Dose	Date Started	Prescribed by

Do you need refills on your current medications? Y N
If yes, please list what you need: _____

Current supplements, vitamins, & Herbs:

Name of Drug	Reason for taking	Dose	Date Started	Prescribed by

Allergies to drugs, environmental, food, etc (state reaction):

_____
_____
_____

Previous only (indicate what is applicable):

Rheumatic fever	Y N	Chicken pox	Y N
Tonsillitis	Y N	Approximate number/frequency _____	
Ear infections	Y N	Approximate number/frequency _____	
Measles	Y N	Rubella	Y N

Other_____

Number of colds a year: _____

Immunizations

Please answer yes or no.

Polio	Y N	Diphtheria	Y N
Tetanus shot	Y N	Chicken pox	Y N
Measles/Mumps/Rubella	Y N	Pertussis	Y N
Hepatitis _____	Y N	HIB	Y N
Flu shot? Date?_____	Y N	Pneumococcal	Y N
Adverse reactions?	Y N	Rotavirus	Y N

Other_____

Please note if you are transferring primary care to our office we ask that you bring a copy of your vaccine schedule to your first visit.

Hospitalizations, Procedures, Injuries (surgeries/special diagnostic studies):

Date	Procedure	Reason	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Additional testing:

Has your child had any of the following tests? If yes, when and where?

EEG _____

Psychological evaluation _____

Hearing tests _____

Speech/language tests _____

Vision Test _____

Other _____

Family History: Indicate whether a family member has the following conditions

Please write M for Maternal side of the family; P for Paternal side of the family

	Diabetes	High Blood Pressure	Heart Dz	Stroke	Mental Disorder	High Cholesterol	Cancer	Autoimmune disorder	Digestive disorder
Father									
Mother									
Grandpa									
Grandma									
Aunt									
Uncle									
Sibling									
Children									

Use the space provided to address any other significant personal or family medical history:

_____

_____

GENERAL Weight _____ Height _____

How would you rate your child's overall health?

Excellent Good Average Fair Poor

What is your present level of commitment to address any underlying causes of your signs and symptoms? (Rate 0-10, 10 being 100% committed) _____

Nutrition and Diet: (circle all that apply)

Does your child follow a specific diet? Y N If yes, please explain_____

Does your child have any food cravings or adversions? _____

What does your child typically eat for each meal?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How much water do they drink each day? _____

Other liquids? _____

Exercise: (circle all that apply)

5-7 days/wk 3-4days/wk 1-2days/wk

45min or more duration per workout 30-45min less than 30min

Stress:

Circle the level of stress your child is usually experiencing (1 is the lowest)
1 2 3 4 5 6 7 8 9 10
Indicate the causes of stress: School Family Residence Health Other:_____

Sleep:
Hours of sleep per night _____ Usual Bedtime _____ Do they wake refreshed? Y N

Energy:
Average daily energy level – Rate 0-10 (10 being the greatest) _____

Environmental:
Has your child ever lived in a smoking household? Y N
Has your child ever had exposures to lead, pesticides, mercury, chemicals, etc? Y N
If yes, what & when? _____

Birth History
Child's birth weight _____ lbs Term: ___ Full ___ Premature ___ Late
Birth: ___ Vaginal ___ Cesarean ___ Other (explain) _____

Any complications with your child's birth? Y N
If yes, what?_____

Did your child have any of the following problems shortly after birth? Please circle.
Rashes Jaundice Colic Birth injuries Seizures Fever Blue baby
Cerebral palsy Birth defects Other_____

Was your child breastfed? Y N How long? _____
Did your child have formula? Y N If yes, what kind? (milk, soy, etc.) _____

Mother's health during pregnancy:

Bleeding	Y N
Illnesses	Y N If yes, what?_____
Medications	Y N If yes, what?_____
Nausea	Y N
Hypertension	Y N
Diabetes	Y N
Physical or emotional trauma	Y N
Cigarettes, alcohol, drug consumption	Y N If yes, what? _____
Thyroid problems	Y N

Mother's age at birth? ____
Does your child have a contagious disease at this time? Y N
If yes, what?_____

Review of Systems – Circle C for Current, P for Past

General:
change in appetite	C	P
chills	C	P
fatigue	C	P
fever	C	P
night sweats	C	P
difficulty falling asleep	C	P
difficulty staying asleep	C	P
weight gain	C	P
weight loss	C	P
headaches	C	P

Allergy:
hives	C	P
congestion	C	P
itching	C	P
watery eyes	C	P

Ears/Eyes/Nose:
decreased hearing	C	P
difficulty swallowing	C	P
dry mouth	C	P
ear pain	C	P
nosebleeds	C	P
ringing of ears	C	P
sinusitis	C	P

Endocrine:
cold intolerance	C	P
excessive sweating	C	P
excessive thirst	C	P
frequent urination	C	P
heat intolerance	C	P
hair thinning	C	P

Respiratory:
cough	C	P
pain with breathing	C	P
shortness of breath	C	P
sputum production	C	P
wheezing	C	P

Cardiac:
chest pain at rest	C	P
chest pain with exertion	C	P
cyanosis (blue skin)	C	P
difficulty laying flat	C	P
irregular heartbeat	C	P
palpitations	C	P

Gastrointestinal:
abdominal pain/colic	C	P
blood in stool	C	P
constipation	C	P
decreased appetite	C	P
diarrhea	C	P
heartburn	C	P
nausea	C	P
vomiting	C	P
gas/bloating	C	P

Female/Male Health (as applicable)
breast lump	C	P
breast pain	C	P
nipple discharge	C	P
heavy menstrual bleeding	C	P
irregular menses	C	P
missed periods	C	P
erectile trouble	C	P
abnormal puberty	C	P

Genitourinary:
blood in urine	C	P
difficulty urinating	C	P
frequent urination	C	P
painful urination	C	P
frequent UTIs	C	P

Musculoskeletal:
joint pain/stiffness	C	P
muscle cramps	C	P
sciatica	C	P
swollen joints	C	P
TMJ pain	C	P
reduced range of motion	C	P

Skin:
acne	C	P
dry skin	C	P

Review of Systems – Circle C for Current, P for Past

rash	C	P
Neurological:		
balance difficulty	C	P
difficulty speaking	C	P
dizziness	C	P
fainting	C	P
loss of strength	C	P
memory loss	C	P
seizures	C	P
Psychiatric:		
anxiety	C	P
depressed mood	C	P
eating disorder	C	P
mental abuse	C	P
physical abuse	C	P
substance abuse	C	P
suicidal thoughts	C	P
nightmares	C	P
behavior problems	C	P
cries easily	C	P