Inland Naturopathic
WELLNESS CENTER
Regenerate Optimize Heal

Pediatric Intake Form

Last Name: _____ **First Name:** _____ **Age:** _____
DOB:_____
Date: _____

List child's medical problems:
1) _____
2) _____
3) _____
4) _____

Last time blood work was done and with what doctor:_____

BIRTH HISTORY
Was child born full term: ☐ Yes ☐ No
Was child born premature: ☐ Yes ☐ No If yes, how early:_____
Delivery: ☐ Vaginal ☐ Caesarian
Were there complications with delivery? ☐ Yes ☐ No
If yes, please explain: _____
Were there complications with pregnancy?: ? ☐ Yes ☐ No
If yes, please explain: _____
Are there any genetic or inheritable disorders? ? ☐ Yes ☐ No
If yes, please explain: _____
Are there any growth delays? ☐ Yes ☐ No
If yes, please explain: _____
Are there any and developmental delays? ☐ Yes ☐ No
If yes, please explain: _____

List All Surgeries, Hospitalizations & Traumas — Including Date Occurred:
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please Note When and Why Each of The Following:
X-rays:_____ MRI/Cat Scans:_____
Ultrasounds:_____ Accidents:_____
Please List All Sensitivities/Allergies/Reactions:
Drugs: _____
Foods: _____
Environment: _____

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***Please Check ALL that Apply**: **LEAVE BLANK** if you've never had the disease.*
***Check DISEASE** if you had the **DISEASE. Check IMMUNIZED** if **IMMUNIZED** with vaccinations.*

CONDITION	DISEASE	IMMUNIZED
COVID-19	☐	☐
Measles	☐	☐
Mumps	☐	☐
Rubella	☐	☐
Chickenpox	☐	☐
German measles	☐	☐
Diptheria	☐	☐
Tetanus	☐	☐
Whooping Cough	☐	☐
Hemophylis (Hib)	☐	☐
Hepatits B	☐	☐

Any Vaccination Reactions?:

_____

List all CURRENT Prescription Medicines, Supplements, & Herbs You Take:

Name of Supplement/Medication	Dosage	Reason(s) for Taking Supplement/Medication	Does It Help? (Yes or No)

HEALTH HABITS

Does child participate in any individual or team sports?_____

EXERCISE:

How often?:_____ What type(s)?:_____

How long?:_____

HOBBIES: _____

SLEEP:

How long per night (hours): _____ Frequent wakening?: ☐ Yes ☐ No

If yes, what is the reason: _____

Nightmares: ☐ Yes ☐ No ☐ Past Wake refreshed: ☐ Yes ☐ No ☐ Past

Naps during the day: ☐ Yes ☐ No ☐ Past Sleep walk: ☐ Yes ☐ No ☐ Past

Grind Teeth: ☐ Yes ☐ No ☐ Past Snore: ☐ Yes ☐ No ☐ Past

INFANT FEEDING

Was child breast-fed?: ☐ Yes ☐ No If so, for how long? _____

Was child formula fed?: ☐ Yes ☐ No If so, what type and for how long? _____

Has solid food been started? ?: ☐ Yes ☐ No If so, at what age was solid food began? _____

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What does child eat for the following meals?:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How much water does child drink? _____

Other beverages? _____

Food aversions: _____

Food cravings: _____

TOXIN EXPOSURE:

Did child grow up near any refinery, or polluted area, or in home with leaded paint? If so, what sort of pollution were you exposed to?: _____

Has child been exposed to solvents, heavy metals, fumes, or other toxic materials?:

_____

Have there been health problems experienced when new carpeting, paint, cabinets, or did other refurbishing?:

_____

Sensitivities to perfumes, gasoline, or other vapors?: _____

Are pesticides, herbicides, other chemicals around your home? _____

SOCIAL LIFE

Who is child raised by, i.e. biological parents…? _____

History of sexual, mental/emotional, physical abuse? : ☐ Yes ☐ No ☐ Past

If so, at what age and by whom?: _____

FAMILY HISTORY:

	Father	**Mother**	**Siblings**	**Grandparents**
Age (Living)	_____	_____	_____	_____
Age (Deceased)	_____	_____	_____	_____
Reason for death	_____	_____	_____	_____
Cancer (Type)	_____	_____	_____	_____

Check Y** for **YES. CHECK N** for **NO.

High blood pressure	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Heart attack/Stroke	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Heart disease	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Asthma/Allergies	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Mental illness	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Auto-immune disease	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Diabetes Mellitus	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
Tuberculoses (TB)	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N

Any other conditions?: _____

REVIEW OF SYSTEMS

Present weight: _____ Height: _____

Weight one year ago: _____ Maximum weight & when: _____

Maximum weight as adult & when: _____ Ideal weight: _____

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***Please Mark ALL Symptoms that Apply**: LEAVE BLANK if you've never had the symptom.*
Check C** if you have the problem **CURRENT**. **Check P** if you had the problem in the **PAST.
Check Y** for **YES. Check N** for **NO.

Frequent Infections: ☐ Yes ☐ No ☐ Past If yes, what types?: _____
Frequent Antibiotic usage: ☐ Yes ☐ No

SKIN

Rash:	☐ C	☐ P
Hives:	☐ C	☐ P
Lump:	☐ C	☐ P
Itchy:	☐ C	☐ P
Psoriasis/Eczema:	☐ C	☐ P
Skin cancer:	☐ C	☐ P

HEAD

Headache:	☐ C	☐ P
Head Injury:	☐ C	☐ P
Migraines:	☐ C	☐ P

EYES

Dry/Watery eyes:	☐ C	☐ P
Blurry vision:	☐ C	☐ P
Styes:	☐ C	☐ P
Strain:	☐ C	☐ P
Decreased hearing:	☐ C	☐ P
Double vision:	☐ C	☐ P
Discharge:	☐ C	☐ P
Dark under eyelids:	☐ C	☐ P
Itchy eyes:	☐ C	☐ P

EARS

Ear pain:	☐ C	☐ P
Ear tubes:	☐ C	☐ P
Drainage:	☐ C	☐ P
Dizziness:	☐ C	☐ P

NOSE

Frequent colds:	☐ C	☐ P
Nosebleeds:	☐ C	☐ P
Congestion:	☐ C	☐ P
Postnasal drip:	☐ C	☐ P
Nasal polyps:	☐ C	☐ P
Seasonal allergies:	☐ C	☐ P

NECK

Stiffness:	☐ C	☐ P
Swollen glands:	☐ C	☐ P
Tension:	☐ C	☐ P

MOUTH/THROAT

Canker sores:	☐ C	☐ P
Cold sores:	☐ C	☐ P
Sore throat:	☐ C	☐ P
Gum disease:	☐ C	☐ P
Cavities:	☐ C	☐ P
Loss of taste:	☐ C	☐ P
Hoarseness:	☐ C	☐ P

CARDIOVASCULAR

Painful breathing:	☐ C	☐ P
Rheumatic Fever:	☐ C	☐ P
Low blood pressure:	☐ C	☐ P
Murmurs:	☐ C	☐ P
Arrhythmias:	☐ C	☐ P
Palpitations:	☐ C	☐ P
Edema:	☐ C	☐ P
Shortness of breath lying down:	☐ C	☐ P
Chest pain:	☐ C	☐ P

URINARY

Frequent urination	☐ C	☐ P
Pain with urination:	☐ C	☐ P
Discharge/Blood:	☐ C	☐ P
Urgency:	☐ C	☐ P

ENDOCRINE

Change in appetite:	☐ C	☐ P
Diabetes:	☐ C	☐ P
Heat intolerance:	☐ C	☐ P
Cold intolerance:	☐ C	☐ P
Thyroid problems:	☐ C	☐ P
Difficulty maintaining weight:	☐ C	☐ P

RESPIRATORY

Cough:	☐ C	☐ P
Shortness of breath with exertion:	☐ C	☐ P
Tuberculosis:	☐ C	☐ P
Bronchitis:	☐ C	☐ P
Pneumonia:	☐ C	☐ P
Asthma:	☐ C	☐ P
Wheezing:	☐ C	☐ P

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GASTROINTESTINAL

Heartburn:	☐ C	☐ P
Bowel movement (BM) frequency:	_____	
Indigestion:	☐ C	☐ P
Recent change in BM:	☐ C	☐ P
Bloating:	☐ C	☐ P
Diarrhea:	☐ C	☐ P
Constipation:	☐ C	☐ P
Nausea:	☐ C	☐ P
Ulcer:	☐ C	☐ P
Vomiting:	☐ C	☐ P
Pancreatitis:	☐ C	☐ P

HEMATOLOGIC

Anemia:	☐ C	☐ P
Easy bruising:	☐ C	☐ P
Easy bleeding:	☐ C	☐ P
Transfusions:	☐ C	☐ P

MUSCULOSKELETAL

Weakness:	☐ C	☐ P
Arthritis:	☐ C	☐ P
Stiffness:	☐ C	☐ P
Leg cramps:	☐ C	☐ P
Tremors:	☐ C	☐ P
Joint pain:	☐ C	☐ P
Scoliosis:	☐ C	☐ P

MALE

Genital malformation:	☐ C	☐ P
Testicular pain or swelling:	☐ C	☐ P
Hernia:	☐ C	☐ P
Discharge:	☐ C	☐ P

FEMALE

Menstruation:	☐ C	☐ P
Age periods began:	_____	
How long periods last:	_____	
How often?:	_____	

NERVOUS

Paralysis:	☐ C	☐ P
Tingling/Numbness:	☐ C	☐ P
Seizures:	☐ C	☐ P
Scoliosis:	☐ C	☐ P

MENTAL/EMOTIONAL

Tantrums	☐ C	☐ P
Depression:	☐ C	☐ P
Anger/Irritability:	☐ C	☐ P
Suicidal:	☐ C	☐ P
Anxiety:	☐ C	☐ P
Fear/Panic:	☐ C	☐ P

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