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Pediatric Patient Intake (birth – 5 yrs)

By completing this profile of your health history, I can offer you more complete naturopathic care. Please be assured that I keep this information confidential.

Name ________________________________ Parent(s) Name _______________________ Birth Date ____________

Address _________________________________ City & State _________________________ Zip ________________

Social Security # ________________________ Home Phone ___________________ Work Phone ________________

Email Address ____

How did you hear about me? ____

Where, when, from whom and for what reason did your child last receive health care? ___________________________
____
____

What are your current health concerns or goals?
1. ____
2. ____
3. ____

Has your child received any vaccinations? Y N
If yes, which ones, including dates: ____
____
____
____
Any problems with vaccinations? Y N Please explain: ____
____
____

Family Health History Y = Yes N = No D = caused death (incl. age) P = In the past
Please indicate if a family member has had any of the following; if yes, please specify who.

Asthma	Y	N	D	P	________________________
Cancer	Y	N	D	P	________________________
Cystic Fibrosis	Y	N	D	P	________________________
Eczema	Y	N	D	P	________________________
Heart Disease	Y	N	D	P	________________________
Mental Illness	Y	N	D	P	________________________
Obesity	Y	N	D	P	________________________
Stroke	Y	N	D	P	________________________
Substance abuse	Y	N	D	P	________________________

Any chronic illnesses or frequent acute illnesses? Y N ____
____
____

Allergies: Foods ____
Drugs ____
Environmental ____

Hospitalizations Y N If yes, please explain & include dates ____________________________________
____
____

Current medications – prescription, vitamins, herbal ____

____

____

Pregnancy, Labor & Delivery: Any problems? Home or hospital birth? Please explain: ________________________

____

____

____

Alcohol or drug use during pregnancy? Y N Please explain ____

____

Gestational Diabetes? Y N Please explain ____

____

Breastfeeding Y N Duration: ________________________________ Age of weaning _____________________

Current problems with breastfeeding? Y N Please explain ____

____

Formula Feeding Y N Cow's milk or soy based? Problems with feeding? ____________________________

____

Health Conditions Y = Yes N = No P = a condition the child has had in past

Skin

Rashes	Y	N	P	Itching	Y	N	P
Eczema	Y	N	P	Cradle cap	Y	N	P

Head

Injuries	Y	N	P	Forceps delivery		Y	N
Headaches	Y	N	P	Fontanelle problems	Y	N	P

Eyes

Lazy eye	Y	N	P	Injuries	Y	N	P
Glasses	Y	N		Infections	Y	N	P

Ears

Infections	Y	N	P	Discharge	Y	N	P
Injuries	Y	N	P	Hearing problems	Y	N	P

Nose & Sinuses

Discharge	Y	N	P	Frequent Colds	Y	N	P
Stuffiness	Y	N	P	Bleeding	Y	N	P

Mouth, Throat & Neck

Teething: 1st Tooth _________months Problems? ____

Molars___________months Problems? ____

Sore throats	Y	N	P	Dental cavities	Y	N	P
Swollen Glands	Y	N	P	Speech problems	Y	N	P
Neck injuries	Y	N	P	Swallowing problems	Y	N	P

Heart

Murmurs	Y	N	P	Congenital problems	Y	N	P

Respiratory

Asthma	Y	N	P	Coughs	Y	N	P
Bronchitis	Y	N	P	Pneumonia	Y	N	P
Wheezing	Y	N	P	Difficulty breathing	Y	N	P

Gastrointestinal

Bowel Movements _______________x/day Color ____________________ Consistency _______________________

Blood in stool	Y	N	P	Constipation	Y	N	P
Vomiting	Y	N	P	Diarrhea	Y	N	P
Gas/bloating	Y	N	P	Change in appetite	Y	N	P
Hernia	Y	N	P	Abdominal pain	Y	N	P

Urinary

Diapers/day ___________________________ Age of Toilet Training ___________________________

Increase frequency Y N P   Pain with urination Y N P

Infections Y N P   Discharge Y N P

Males:

Inguinal hernia Y N P   Undescended testicle Y N P

Females

Inguinal hernia Y N P   Vaginal discharge Y N P

Musculoskeletal

Fractures Y N P   Muscle weakness or pain Y N P

Neurological

TremorsY N P   Seizures Y N P

Paralysis Y N P   Delayed Development Y N P

Endocrine

Excessive hunger Y N P   Excessive thirst Y N P

Excessive fatigue Y N P   Difficulty sleeping Y N P

Mental & Emotional Health

Fears Y N ___________________________

Excessive anger Y N ___________________________

Mood swings Y N ___________________________

Separation anxiety Y N ___________________________

Socialization, Personality, & Home life

Sleeping patterns ___________________________

____

Interaction with other children: Leader or follower? ___________________________

____

Siblings Y N Ages & gender ___________________________

Watches TV Y N Hours daily _________ Video Games Y N Hours daily _______________

Do you read books together? Y N ___________________________

Brushes teeth Y N Bathing routine ___________________________

Problems with social interactions? ___________________________

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Consent to Naturopathic Treatment Provided by Breana McElgunn, ND

I. This is to acknowledge that I have been informed and understand that:
   i) Any treatment or advice provided to me as a patient of Dr. Breana McElgunn is not mutually exclusive from any treatment or advice that I may be receiving now or in the future, from another health care provider.
   ii) I am at liberty to seek or continue medical care from a physician, surgeon, or other health care provider
   iii) I understand that Dr. McElgunn is not preventing me from seeking or following the advice of another licensed health care provider.
   iv) The treatment and therapies provided to me by Dr. McElgunn may be different from those offered by another licensed health care provider.

II. I agree to pay for any fees for services, costs of supplements and homeopathic remedies, cost of laboratory tests, or other fees that are not covered by my insurance plan, at the time of the visit.

III. I hereby authorize and consent to treatment.

___________________________ ___________________

Signature Parent/Guardian   Date