

Integrative Family Wellness Center
Kim E Saxe, N.D.
PEDIATRIC INTAKE FORM (0-12 years)

Name: _____ Date: _____
Age: _____ Date of Birth: ____/____/____ Female: ____ Male: ____
Mother's name: _____ Father's name: _____
Address: _____
City: _____ State: _____ Zip code: _____
Phone # (home): (____) _____ Parent's # (work): (____) _____
Parent's e-mail address: _____
How did you hear about our clinic? _____

Health History Questionnaire

What are your child's most important health problems? List as many as you can in order of importance:

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

Does your child have a contagious disease at this time? Y N

If yes, what? _____

Previous Illnesses

Rheumatic fever	Y N	German measles	Y N
Chicken pox	Y N	Measles	Y N
Tonsillitis	Y N	approx. number	_____
Ear infections	Y N	approx. number	_____
Other	Y N	list	_____

Has your child had any of the following tests? When Where

Electroencephalogram (EEG) _____

Psychological evaluation _____

Hearing tests _____

Speech/Language tests _____

Hospitalizations/Surgeries/ Injuries

What hospitalizations, surgeries or injuries has your child had?

Immunizations

Polio	Y N	Pertussis	Y N
Tetanus shot	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Influenza	Y N
Any adverse reactions	Y N	If yes, what?	_____

Allergies

Is your child hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental? _____

Breast fed? _____ How long? _____ Formula? _____ milk/soy? _____

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

Please list ANY prescription medications, over the counter medications, vitamins or other supplements your child is taking:

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

REVIEW OF SYSTEMS

Y= a condition now P= significant problem in the past N= never had

MENTAL/EMOTIONAL

Mood swings	Y P N	Anxiety/nervousness	Y P N
Irritability	Y P N	Cries easily	Y P N
Hyperactivity	Y P N	Unusual fears	Y P N
Introvert/extrovert	Y P N	Sleep problems	Y P N
Motion/car sickness	Y P N	Nightmares	Y P N

ENDOCRINE

Heat/cold intolerance	Y P N	Fatigue	Y P N
Excessive thirst	Y P N	Excessive hunger	Y P N
Low blood sugar	Y P N	High blood sugar	Y P N

SKIN

Rashes	Y P N	Eczema, hives	Y P N
Acne/boils	Y P N	Itching	Y P N

HEAD

Headaches	Y P N	Head injury	Y P N
Dizzy spells	Y P N	High fevers	Y P N

EYES

Glasses or contacts	Y P N	Tearing or dryness	Y P N
Eye pain/ strain	Y P N		

EARS

Earaches	Y P N	Impaired hearing	Y P N
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NOSE AND SINUSES

Frequent colds	Y P N	Nose bleeds	Y P N
Stuffiness	Y P N	Hayfever	Y P N
Sinus problems	Y P N	Loss of smell	Y P N

MOUTH AND THROAT

Frequent sore throat	Y P N	Canker sores	Y P N
Breath odor	Y P N		

RESPIRATORY

Cough	Y P N	Wheezing	Y P N
Asthma	Y P N	Bronchitis	Y P N

CARDIOVASCULAR

Heart disease	Y P N	Murmurs	Y P N
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GASTROINTESTINAL

Belching/passing gas	Y P N	Stomach aches	Y P N
Constipation	Y P N	Diarrhea	Y P N
Bowel movements	How often		

URINARY

Pain on urination	Y P N	Frequent urination	Y P N
Infections	Y P N	Kidney stones	Y P N

MUSCULOSKELETAL

Joint stiffness/pain	Y P N	Muscle spasms/cramps	Y P N
Broken bones	Y P N		

BLOOD/PERIPHERAL VASCULAR

Anemia	Y P N	Easy bleeding/bruising	Y P N
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Is there any information about your child's health that you would like to add?

What expectations do you have for your child from working with our clinic?

Welcome! I am honored to be of service for you and your child!