



acupuncturekitchen

## Acupuncture Kitchen Intake Form For Naturopathic Medicine

### Pediatric Intake Form – Infant to Twelve Years Old

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex M or F

Grade of School: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mother's Name and occupation: \_\_\_\_\_

Father's Name and occupation: \_\_\_\_\_

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

Regular Pediatrician name and city located in: \_\_\_\_\_

Reason for Office Visit: \_\_\_\_\_ Well Baby Check? Yes No \_\_\_\_\_

Has child been seen by any other doctor(s) for this complaint? Yes No

Has child had any blood work done? If yes, please list what:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any operations or hospitalizations and year occurred:

- 1.
- 2.
- 3.
- 4.

Please list all medicines (from drugstore or prescription) child is on now:

- 1.
- 2.
- 3.
- 4.

Please list all supplements child is taking:

- 1.
- 2.
- 3.
- 4.

Any known Allergies to food, drugs, environment, animals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Previous Medical History

**Yes** indicates the child gets the problem regularly; **No** indicates the child never had the problem; **Past** indicates the child had the problem in the past but not recently. Please circle the correct one for your child.

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 medicine 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 or on alternate schedule

Hep B	Yes	No	Some
RotaVirus	Yes	No	Some
DPT:	Yes	No	Some
Hib:	Yes	No	Some
Pneumococcal	Yes	No	Some
Polio (inactivated)	Yes	No	Some
Influenza	Yes	No	Some
MMR	Yes	No	Some
Varicella (chkpox)	Yes	No	Some
Hep A	Yes	No	Some
Meningococcal	Yes	No	Some

Other: \_\_\_\_\_

Any reactions to vaccinations? If so, please explain: \_\_\_\_\_

## Family History

Allergies: Yes No  
Cancer: Yes No  
Cardiovascular disease: Yes No  
Diabetes mellitus: Yes No

Obesity: Yes No  
Tuberculosis: Yes No  
Mental Illness: Yes No

## Mother's Pregnancy history

Age at conception: \_\_\_\_\_ Have other children already? Yes No

## Health During Pregnancy:

Smoking: Yes No  
Coffee: Yes No  
Recreational drugs: Yes No  
Preeclampsia: Yes No  
Vaginal birth: Yes No

Diabetes: Yes No  
Nausea/Vomiting: Yes No  
Emotional Stress: Yes No  
Length of Labor: \_\_\_\_\_  
Traumatic birth: Yes No

If the birth was difficult, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Health of baby at birth: \_\_\_\_\_  
\_\_\_\_\_

APGAR Score: \_\_\_\_\_

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: \_\_\_\_\_  
Develop Teeth: \_\_\_\_\_

## Health History of Child

Jaundice as baby: Yes No  
Cradle cap: Yes No  
Eczema or psoriasis: Yes No  
Diarrhea: Yes No  
Constipation: Yes No  
Finicky eating: Yes No  
Poor teeth: Yes No  
Chronic sniffles: Yes No

Colic: Yes No  
Anemia: Yes No  
Asthma: Yes No  
Warts: Yes No  
Nightmares: Yes No  
Bed-wetting: Yes No  
Tantrums: Yes No  
Disobedient: Yes No

Bad foot odor: Yes No  
Very sweaty baby/child: Yes No  
Hyperactivity: Yes No  
Growing pains: Yes No

Fears/Phobia: Yes No  
Diaper Rash: Yes No  
Early Puberty: Yes No  
Stomach aches: Yes No

Any particular household stressors child has witnessed or gone through:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Known Allergies to Food, Medicines, Pollens, Dander, etc.: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Typical Day's Diet:**

Breakfast: \_\_\_\_\_  
Snack: \_\_\_\_\_  
Lunch: \_\_\_\_\_  
Snack: \_\_\_\_\_  
Supper: \_\_\_\_\_  
Snack: \_\_\_\_\_

**Toxin Exposure:**

Has the child ever lived near a refinery or other highly polluted area? \_\_\_\_\_

Has the child ever lived in a house with lead paint? \_\_\_\_\_

Has the child ever lived in a house that had new paint, cabinets, carpeting, mattress installed and did that seem to affect their health at all? \_\_\_\_\_

Do you spray pesticides or herbicides around the house or use other toxic chemicals? \_\_\_\_\_

Does the child seem particularly sensitive to perfumes or other vapors? Yes No explain \_\_\_\_\_

\_\_\_\_\_