Pediatric Intake Form

Welcome. Our philosophy and approach to medicine is wholistic and seeks to understand all factors that may be affecting your health. This intake form will help us to uncover the underlying causes of your health concerns. If any of these questions are difficult for you to answer, please let Dr. Monette know.

Please fill out as much as is possible and fax or mail it to our office at least two days prior to your first visit. If this is not possible, bring in the completed form to your first visit. We look forward to seeing you.

Today's date _____

Name of child _____

Date of birth _____ Age _____ Grade in School _____ Sex: ☐ Male ☐ Female

Parent(s) name _____

Parents are (check one) ☐ married ☐ separated ☐ divorced ☐ living together ☐ other

Health Concerns

Reason for office visit _____

Major complaints in order of importance to you

1. _____

2. _____

3. _____

Have you received treatment for any of the above conditions? ☐ yes ☐ no If yes, please explain: _____

_____

What would you most like to accomplish on your first visit? _____

_____

Healthcare Providers

Who is your pediatrician? _____ (name) (address)

When was your last physical exam? _____ (month) (year)

Who is your dentist? _____ (name) (address)

When did you last visit the dentist? _____ (month) (year)

Medications | Supplements

List prescription medications, over-the-counter medications, vitamins, minerals, herbs, etc.

Medication / Supplement name	How much do you take daily?	Why are you taking this medication / supplement?

Have you ever been treated with or used any of the following? (check all that apply)

- ☐ antibiotics more than 2 weeks
- ☐ antibiotics more than 2 times/year
- ☐ antihistamines
- ☐ laxatives/stool softeners
- ☐ steroids
- ☐ stimulants

Allergies

Please list all known allergies to (please describe the adverse reaction).

- medications (prescription, over-the-counter, recreational)
- supplements
- vaccinations
- food
- environment

_____

_____

_____

Past Medical History

Surgeries / Hospitalization

Procedure / Reason	Year

Major Injuries

Injury	Year

Vaccination History

Have you received the following vaccinations?

MMR ☐ Yes ☐ No ☐ Some
DPT ☐ Yes ☐ No ☐ Some
Hib ☐ Yes ☐ No ☐ Some
Polio ☐ Yes ☐ No ☐ Some
Hep B ☐ Yes ☐ No ☐ Some
Chickenpox ☐ Yes ☐ No ☐ Some
Other _____

Have you had any reactions to vaccinations? ☐ Yes ☐ No If yes, explain _____

_____

Environmental Exposure

Have you ever lived in a house with lead paint?	Y | N
Have you ever experienced health problems after putting down new carpets, painting, or doing renovations?	Y | N
Are you sensitive to perfume, gasoline or other vapors?	Y | N
Have you ever lived near a refinery or polluted area?	Y | N
Have you ever lived in a home more than 50 years old?	Y | N
Do you have mercury dental fillings? How many? _____	Y | N
Have you had any dental root canal procedures?	Y | N
Do you have any surgical implants?	Y | N
Do you live near power lines?	Y | N
Do you spray pesticides or herbicides around the house or use other toxic chemicals?	Y | N

Family History

Relative	Age if living	Age if deceased	General Health | Ailments
Mother			
Father			
Siblings			
Maternal grandmother			
Maternal grandfather			
Paternal grandmother			
Paternal grandfather			

Has your relative(s) ever had any of the following?

Condition	Check One	Which relative(s)?	Condition	Check One	Which relative(s)?
Allergies	☐Y ☐N		Asthma	☐Y ☐N	
Cancer	☐Y ☐N		Cardiovascular Disease	☐Y ☐N	
Diabetes	☐Y ☐N		Eczema	☐Y ☐N	
Obesity	☐Y ☐N		Mental Illness/Depression	☐Y ☐N	

Birth History

Mother's age at conception _____ Child's birth order (youngest, eldest) _____

Number of weeks of pregnancy at birth _____ Length of labor _____

Vaginal or caesarean birth ☐ V ☐ C Please explain any complications _____

Health of baby at birth _____

Was the child breastfed? ☐ yes ☐ no For how long? _____

Was the child ever on formula? ☐ yes ☐ no If yes, for how long and brand used? _____

When was the child introduced to solid food? _____

When did the child develop teeth? _____

When did the child start to walk? _____ When did the child start to talk? _____

Did the child have any of the following as an infant (check if yes)

☐ anemia ☐ asthma ☐ diaper rash

☐ colic ☐ cradle cap ☐ eczema ☐ jaundice

Personal

Are you exposed to secondhand smoke? _____

How much time to you spend outdoors per week? _____

Diet

Record a typical day's diet.

Breakfast _____

Snack _____

Lunch _____

Snack _____

Dinner _____

Snack _____

How much water do you drink daily? _____ What type of water do you drink? _____

How many nonwater beverages do you drink per week (soda, juice)? _____ Do you eat organic food? ☐Y ☐N

How often do you eat out? _____

What foods do you crave? _____

Do you have dietary restrictions? _____

What is your current weight? _____

Review of Systems

Y = presently have

N = never have had

P = have had in the past

Skin	
Rashes	☐ Y ☐ N ☐ P
Eczema	☐ Y ☐ N ☐ P
Acne	☐ Y ☐ N ☐ P
Bruise easily	☐ Y ☐ N ☐ P
Itching	☐ Y ☐ N ☐ P
Dryness	☐ Y ☐ N ☐ P
Cradle cap	☐ Y ☐ N ☐ P
Diaper rash	☐ Y ☐ N ☐ P
Warts	☐ Y ☐ N ☐ P

General	
Fever	☐ Y ☐ N ☐ P
Fatigue	☐ Y ☐ N ☐ P
Frequent colds	☐ Y ☐ N ☐ P
Early puberty	☐ Y ☐ N ☐ P
Poor foot odor	☐ Y ☐ N ☐ P

Neurological	
Hyperactivity	☐ Y ☐ N ☐ P

Head	
Headaches	☐ Y ☐ N ☐ P
Migraines	☐ Y ☐ N ☐ P
Injury	☐ Y ☐ N ☐ P

Respiratory	
Cough	☐ Y ☐ N ☐ P
Wheezing	☐ Y ☐ N ☐ P
Asthma	☐ Y ☐ N ☐ P
Difficult breathing	☐ Y ☐ N ☐ P

Eyes | Ears | Nose | Throat	
Glasses / contacts	☐ Y ☐ N ☐ P
Vision problems	☐ Y ☐ N ☐ P
Frequent ear pain	☐ Y ☐ N ☐ P
Impaired hearing	☐ Y ☐ N ☐ P
Ear discharge	☐ Y ☐ N ☐ P
Jaw clicking / pain	☐ Y ☐ N ☐ P
Nosebleeds	☐ Y ☐ N ☐ P
Stuffiness	☐ Y ☐ N ☐ P
Hay fever	☐ Y ☐ N ☐ P
Chronic sniffles	☐ Y ☐ N ☐ P
Post nasal drip	☐ Y ☐ N ☐ P
Frequent sore throat	☐ Y ☐ N ☐ P
Gum problems	☐ Y ☐ N ☐ P
Teeth problems	☐ Y ☐ N ☐ P
Canker sores	☐ Y ☐ N ☐ P
Swollen glands	☐ Y ☐ N ☐ P

Cardiovascular	
Palpitations	☐ Y ☐ N ☐ P
Murmur	☐ Y ☐ N ☐ P
Anemia	☐ Y ☐ N ☐ P

Gastrointestinal	
Nausea	☐ Y ☐ N ☐ P
Vomiting	☐ Y ☐ N ☐ P
Diarrhea	☐ Y ☐ N ☐ P
Constipation	☐ Y ☐ N ☐ P
Colic	☐ Y ☐ N ☐ P
Stomachaches	☐ Y ☐ N ☐ P
Finicky eating	☐ Y ☐ N ☐ P
Undigested food in stool	☐ Y ☐ N ☐ P
Itching around rectum	☐ Y ☐ N ☐ P
How many bowel movements per day? _____	
Is this a change?	☐ Y ☐ N ☐ P
Have you ever travelled to a third world country? If so, for how long? _____	

Musculoskeletal	
Growing pains	☐ Y ☐ N ☐ P
Muscle spasms	☐ Y ☐ N ☐ P
Muscle cramps	☐ Y ☐ N ☐ P

Urinary	
Pain on urination	☐ Y ☐ N ☐ P
Increased frequency	☐ Y ☐ N ☐ P
Frequent infections	☐ Y ☐ N ☐ P
Bed-wetting	☐ Y ☐ N ☐ P
Awaken to urinate	☐ Y ☐ N ☐ P

Endocrine	
Very sweaty	☐ Y ☐ N ☐ P
Sluggish after eating	☐ Y ☐ N ☐ P
Generally feel hot	☐ Y ☐ N ☐ P
Generally feel cold	☐ Y ☐ N ☐ P
Mental sluggishness	☐ Y ☐ N ☐ P
Do you awake feeling rested?	☐ Y ☐ N ☐ P

Mental | Emotional	
Abuse	☐ Y ☐ N ☐ P
Anxiety / Nervousness	☐ Y ☐ N ☐ P
Disobedient	☐ Y ☐ N ☐ P
Mood swings	☐ Y ☐ N ☐ P
Mental illness	☐ Y ☐ N ☐ P
Nightmares	☐ Y ☐ N ☐ P
Panic attacks	☐ Y ☐ N ☐ P
Phobias | Fears	☐ Y ☐ N ☐ P
Prolonged sadness or grief	☐ Y ☐ N ☐ P
Tantrums	☐ Y ☐ N ☐ P

Immune	
Chronic infections	☐ Y ☐ N ☐ P
Frequent antibiotics	☐ Y ☐ N ☐ P
Frequent colds / flus	☐ Y ☐ N ☐ P
Cold sores	☐ Y ☐ N ☐ P
Swollen glands or lymph nodes	☐ Y ☐ N ☐ P
Slow wound healing	☐ Y ☐ N ☐ P
Frequent sore throat	☐ Y ☐ N ☐ P
Chickenpox	☐ Y ☐ N ☐ P

Rate your energy level between 1 and 10 (1=extreme fatigue, 10=most energetic) 1

Rate your stress level between 1 and 10 (1=less stress, 10=extremely stressed) 1

At what time of the day is your energy the best? _____

At what time of the day is your energy the worst? _____

How many hours of sleep do you get a night? _____

Thank you for taking the time to fill out this form. We look forward to seeing you.

Guardian's Signature _____ Date _____