

Hegnauer Holistic Health

Dr. Amanda Hegnauer

Naturopathic Doctor

Pediatric Intake Form

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Grade in School: _____

Mother's Name and Occupation: _____

Father's Name and Occupation: _____

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

Reason for Office Visit: _____

Has child been seen by any other doctor (s) for this complaint? _____

Regular Pediatrician name and city located in: _____

Last time you had blood work done and with what physician: _____

List All Surgeries & Hospitalizations, including date occurred:

- 1) _____ 4) _____
- 2) _____ 5) _____
- 3) _____ 6) _____

List All medicines (prescriptions) child is on now:

- 1) _____ 4) _____
- 2) _____ 5) _____
- 3) _____ 6) _____

List all supplements child is taking:

- 1) _____ 4) _____
- 2) _____ 5) _____
- 3) _____ 6) _____

Any known allergies to food, drugs, environment, animals: _____

Past Medical History

Indicate Y (yes) if the child gets the problem regularly; N (no) if the child never had the problem; and P (past) if the child had the problem in the past, but no recently. Please circle the correct one for your child.

Ear Infections: Y N P If has had, how many total: _____

Colds: Y N P If has had, how many total: _____

Strep Throat: Y N P If has had, how many total: _____

How many times has the child taken antibiotics: _____

What other medications has the child taken and how often:

- 1) _____ 3) _____
- 2) _____ 4) _____

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Hearing Tests Normal: Yes No Not Tested Vision Tests Normal: Yes No Not Tested
Speech Impediments: Yes No Not Tested Learning Impediments: Yes No Not Tested

Vaccination History

Please indicate YES, has had; NO, no not; SOME, did not finish all shots:

MMR: Yes No Some DPT: Yes No Some Hep B: Yes No Some

Hib: Yes No Some Chicken Pox: Yes No Some Polio: Yes No Some

Other: _____

Any reactions to vaccination? If so, please explain: _____

Family History

Allergies: Y N P Obesity: Y N P Cancer: Y N P

Tuberculosis: Y N P Mental Illness: Y N P Cardiovascular disease: Y N P

Diabetes mellitus: Y N P Asthma: Y N P Other: _____

Mother's Pregnancy History

Age of conception: _____ Did she have other children already: Yes No How many: _____

Smoking: Y N Coffee: Y N Alcohol/Recreational drugs: Y N

Nausea/Vomiting: Y N Emotional Stress: Y N

Preeclampsia: Y N Gestational Diabetes: Y N

Length of Labor: _____ Vaginal Birth or C-Section (circle one)

Traumatic Birth: Y N If yes, please explain: _____

Health History of Child

Weight at birth: _____ Health of baby at birth: _____

Child Breastfed: Y N 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: _____

Jaundice as baby: Y N

Colic: Y N

Cradle Cap: Y N

Anemia: Y N

Eczema or Psoriasis: Y N

Asthma/Wheezing: Y N

Diarrhea: Y N

Warts: Y N

Constipation: Y N

Nightmares: Y N

Finicky Eating: Y N

Bed-wetting: Y N

Poor Teeth: Y N

Tantrums: Y N

Chronic Sniffles: Y N

Disobedient: Y N

Bad Foot Odor: Y N

Fears/Phobia: Y N

Very Sweaty Baby/Child: Y N

Diaper Rash: Y N

Hyperactivity: Y N

Early Puberty: Y N

Growing Pains: Y N

Stomach Aches: Y N

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Any Particular household stressors child was witnessed or gone through:

- 1) _____ 3) _____
- 2) _____ 4) _____

Toxin Exposure

Has the child ever lived near a refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to?

Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health at all?

Does the child seem particularly sensitive to perfumes, gasoline or other vapors? _____

Do you spray pesticides, herbicides or other chemicals around your home? _____

Typical Day's Diet

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: Water: _____ Soda: _____

Dairy: _____ Soy: _____ Other: _____

How often do you and your child eat out weekly? What restaurants do you frequent?

Additional notes: _____
