Hegnauer Holistic Health
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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)_____

2)_____

3)_____

4)_____

5)_____

6)_____

List All medicines (prescriptions) child is on now:

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

List all supplements child is taking:

1)_____

2)_____

3)_____

4)_____

5)_____

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)_____

2)_____

3)_____

4)_____

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	Asthma/Wheezing:	Y N
Colic:	Y N	Diarrhea:	Y N
Cradle Cap:	Y N	Warts:	Y N
Anemia:	Y N	Constipation:	Y N
Eczema or Psoriasis:	Y N	Nightmares:	Y N

Finicky Eating:	Y	N	Very Sweaty Baby/Child:	Y	N
Bed-wetting:	Y	N	Diaper Rash:	Y	N
Poor Teeth:	Y	N	Hyperactivity:	Y	N
Tantrums:	Y	N	Early Puberty:	Y	N
Chronic Sniffles:	Y	N	Growing Pains:	Y	N
Disobedient:	Y	N	Stomach Aches:	Y	N
Bad Foot Odor:	Y	N			
Fears/Phobia:	Y	N			

Any Particular household stressors child was witnessed or gone through:

1)_____

2)_____

3)_____

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:

_____

_____

_____

_____