Hegnauer Holistic Health
Dr. Amanda Hegnauer, ND
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
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	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:

____

____

____

____