Grand Rapids Natural Health, LLC

www.grnaturalhealth.com

638 Fulton St. W Suite B
Grand Rapids, MI 49504
T (616) 264-6556
F (616) 432-3564

# Grand Rapids Natural Health Pediatric Intake Form

Name_______________________________________________ **Preferred Name: ________________**

Date of birth _____________________ Age ______ Sex M or F

Grade in School: _________________________________________

Address: __________________________________________________________

City: __________________ State: _______________ Zip: _____________

Mother's Name and occupation: ______________________________________________ Phone: __________________

Father's Name and occupation: ______________________________________________ Phone: __________________

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

Regular Pediatrician name and city located in: ____________________________________________

**Reason for today's Office Visit: _________________________________________________**

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

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

_________________________________________________________________________________

Please list any operations or hospitalizations and year occurred:

1.
2.
3.

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 and their reaction (*e.g. peanuts causes hives*):

____________________________________________________________________________________________________

_______________________________________________________________________________

___________________________________________________________________________________________

**Previous medical history**

**Yes** indicates the child gets the problem regularly; **No** indicates the child never had the problem; **P**ast 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 medicines 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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| MMR: | Yes | No | Some | DPT: | Yes | No | Some |
| Hep B: | Yes | No | Some | Hib: | Yes | No | Some |
| Chickenpox: | Yes | No | Some | Polio: | Yes | No | Some |

Other:_____________________________

Any reactions to vaccinations? If so, please explain: _______________________

___________________________________________________________________

**Family history**

| | | | | | |
|---|---|---|---|---|---|
| Allergies: | Yes | No | Obesity: | Yes | No |
| Cancer: | Yes | No | Tuberculosis: | Yes | No |
| Cardiovascular disease: | Yes | No | Mental Illness: | Yes | No |
| Diabetes mellitus: | Yes | No | | | |

**Mother's Pregnancy history**

Age at conception:_________

Did she have other children already? Yes No

**Mother's Health During Pregnancy**

| | | | | | | |
|---|---|---|---|---|---|---|
| Smoking: | Yes | No | Diabetes: | Yes | No |
| Coffee: | Yes | No | Nausea/Vomiting: | Yes | No |
| Recreational drugs: | Yes | No | Emotional Stress: | Yes | No |
| Preeclampsia: | Yes | No | Length of Labor: | __________ | |
| Vaginal birth: | Yes | No | Traumatic birth: | Yes | No |

If the birth was difficult, please explain:
_____________________________________________________________________________

Child's Birth Weight: :______________

Health of baby at birth:__________________________________________________________

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:________________

When did child develop teeth:________________________

**Health History of child**

| | | | | | |
|---|---|---|---|---|---|
| Jaundice as baby: | Yes | No | Colic: | Yes | No |
| Cradle cap: | Yes | No | Anemia: | Yes | No |
| Eczema or psoriasis: | Yes | No | Asthma: | Yes | No |
| Diarrhea: | Yes | No | Warts: | Yes | No |
| Constipation: | Yes | No | Nightmares: | Yes | No |
| Finicky eating: | Yes | No | Bed-wetting: | Yes | No |
| Poor teeth: | Yes | No | Tantrums: | Yes | No |
| Chronic sniffles: | Yes | No | Disobedient: | Yes | No |
| Bad foot odor: | Yes | No | Fears/Phobia: | Yes | No |
| Very sweaty baby/child: | Yes | No | Diaper Rash: | Yes | No |
| Hyperactivity: | Yes | No | Early Puberty: | Yes | No |
| Growing pains: | Yes | No | Stomach aches: | Yes | No |

**Any particular household stressors child has witnessed or gone through:**

1.______________________________________________________________________________

2.______________________________________________________________________________

**Diet**

Foods**:** Please list in each food group, the foods that your child currently eats. Grain would include all breads, pasta and other related foods. If more, please list most common foods.

| Meat: | ___________ | Fruit: | ___________ | Veg: | ___________ | Grain: | ___________ |
|---|---|---|---|---|---|---|---|
| | ___________ | | ___________ | | ___________ | | ___________ |
| | ___________ | | ___________ | | ___________ | | ___________ |
| | ___________ | | ___________ | | ___________ | | ___________ |
| | ___________ | | ___________ | | ___________ | | ___________ |
| | ___________ | | ___________ | | ___________ | | ___________ |
| Other: | ___________ | | ___________ | | ___________ | | ___________ |

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 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?___________________

**Additional Comments can be noted on back of last page.**