



NATURAL HEALTH CARE

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****Welcome to our clinic****

Pediatric Patient Intake Form

Patient Name _____ Date _____

Parent/Guardian Name _____

Address _____

City _____ State _____ Zip Code _____

Telephone (home) _____ (cell) _____

Parent E-mail _____

Emergency contact _____ Phone _____

Relationship _____ Address _____

How did you hear about this clinic: _____

Demographics

Patient's Age: _____ Date of Birth: _____ Gender: _____

Thank You For Your Time & Effort

Holistic health care and preventive medicine are only possible when the physician has full understanding of each patient, physically, mentally, and emotionally. Your time, thoughtfulness, and honesty in filling out the information below will greatly improve the quality of your holistic healthcare experience.

Health History Questionnaire

Does your child have a primary care doctor? Y N

Name: _____ Location: _____ Phone: _____

Are they currently under the care of any other physician/healthcare provider?

Name: _____ Location: _____ Phone: _____

Specialty/Reason for seeing: _____

Name: _____ Location: _____ Phone: _____

Specialty/Reason for seeing: _____

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Specialty/Reason for seeing: _____

What are your child's most important health concerns? List in order of importance.

1. _____ Onset? _____

2. _____ Onset? _____

3. _____ Onset? _____

4. _____ Onset? _____

5. _____ Onset? _____

Does your child have a contagious disease at this time? Y N

If yes, what? _____

What is your present level of commitment to address any *underlying causes* of your child's signs & symptoms? Rate from 0 to 10, 10 being 100% committed.

0% 0 1 2 3 4 5 6 7 8 9 10 100%

What three expectations do you have of me personally as your health care provider?

General

Height: _____

Weight: _____

Maximum weight: _____ When? _____

How would you rate your child's overall health?

Excellent Good Average Fair Poor

Family History

In order to create a *preventive* wellness plan, it is important to know what diseases run in your family.

Check all that apply: Father Mother Sibling Aunt/Uncle Grandparents Other

Cancer Type: _____	_____	_____	_____	_____	_____	_____
Kidney disease	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Hay fever	_____	_____	_____	_____	_____	_____
Heart disease	_____	_____	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Autoimmune disease	_____	_____	_____	_____	_____	_____
Hives	_____	_____	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Mental illness	_____	_____	_____	_____	_____	_____
Alcoholism	_____	_____	_____	_____	_____	_____
Obesity	_____	_____	_____	_____	_____	_____
Hypothyroidism	_____	_____	_____	_____	_____	_____
Depression/Anxiety	_____	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____	_____

Previous Illnesses

Rheumatic fever Y N
 Chicken pox Y N
 Tonsillitis Y N Approximate number _____
 Ear infections Y N Approximate number _____
 Measles Y N
 Rubella Y N
 Other _____

of colds each year _____

Immunization History

Please answer yes or no.

Polio	Y N	Diphtheria	Y N
Tetanus shot	Y N	Chicken pox	Y N
Measles/Mumps/Rubella	Y N	Pertussis	Y N
Hepatitis _____	Y N	HIB	Y N
Flu shot? Date? _____	Y N	Other _____	
Adverse reactions?	Y N		

If yes, what? _____

Mental Health

Has your child had any times of major psychological trauma? Y N

Age: _____

Age: _____

Age: _____

Hospitalizations, Surgeries, Lab work, & Imaging

Please list dates of any hospital stays and reason for admittance.

Has your child had any of the following tests? If yes, when and where?

EEG? _____

Psychological evaluation? _____

Hearing tests? _____

Speech/language tests? _____

Other? _____

Medications & Supplements

Please list any **prescriptions & over the counter medications** your child takes.

Drug: _____	Dose: _____	How long? _____
Drug: _____	Dose: _____	How long? _____
Drug: _____	Dose: _____	How long? _____
Drug: _____	Dose: _____	How long? _____
Drug: _____	Dose: _____	How long? _____
Drug: _____	Dose: _____	How long? _____

Please list any **supplements** your child is currently taking. Please include the **brand**.

_____	Dose: _____	How long? _____
_____	Dose: _____	How long? _____
_____	Dose: _____	How long? _____
_____	Dose: _____	How long? _____
_____	Dose: _____	How long? _____
_____	Dose: _____	How long? _____

Allergies

Please list any drug, food, or environmental allergies or sensitivities.

_____	Effect: _____
_____	Effect: _____
_____	Effect: _____
_____	Effect: _____
_____	Effect: _____

Was your child breastfed? Y N How long? _____

Did your child have formula? Y N If yes, what kind? (milk, soy, etc.) _____

Diet

Does your child follow a specific diet? Y N

If yes, please circle.

Vegetarian Vegan Paleolithic Anti-inflammatory Blood-type Atkins

Low-fat/low calorie Gluten-free Dairy-free Other _____

What does your child typically eat for each meal?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How much water do they drink each day? _____

Toxic Exposures

Has your child ever lived in a smoking household? Y N

Has your child ever had exposures to lead, pesticides, mercury, chemicals etc? Y N

If yes, what & when? _____

Birth History

Child's birth weight _____ lbs

Term: ___ Full ___ Premature ___ Late

Any complications with your child's birth? Y N

If yes, what? _____

Did your child have any of the following problems shortly after birth? Please circle.

Rashes Jaundice Colic Birth injuries Seizures Fever Blue baby

Cerebral palsy Birth defects Other _____

Mother's health during pregnancy:

Bleeding	Y N
Illnesses	Y N If yes, what? _____
Medications	Y N If yes, what? _____
Nausea	Y N
Hypertension	Y N
Diabetes	Y N
Physical or emotional trauma	Y N
Cigarettes, alcohol, drug consumption	Y N If yes, what? _____
Thyroid problems	Y N

Mother's age at birth? _____

Review of Symptoms Please circle all that apply.

Hives	Burning urine	Bloody urine	Eczema
Cries easily	Bleeding gums	Heart murmur	Nervous/anxiety
Nose bleeds	Vomiting spells	Sleep problems	Asthma
Acne	Anemia	Night sweats	High fevers
Jaundice	Sensitive to light	Chronic rash	Stomach aches
Diarrhea	Hearing loss	Easy bruising	Sore throats
Flat feet	No appetite	Body/breath odor	Constipation/diarrhea
Nightmares	Frequent colds	Bleeding tendency	Unusual fears
Wheezing	Joint pain	Excessive fatigue	Cough
Dizzy spells	Hair loss	Frequent urination	Allergies/runny nose
Sadness	Difficulty learning	Behavior problems	Other (explain on next page)

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Is there any other information about your child's health that you'd like us to know? Please include if this information can be discussed in front of your child.

**Thank you for your time and patience in filling out these forms.*

**Be sure to bring them along to your child's visit, along with any recent blood work or relevant medical records.*

**I look forward to working with you and your child as together we make progress toward a more healthy & optimal life...*

Yours in health,

Craig T. Fasullo, ND