

Providence Wholistic Healthcare

Integrative Natural Family Medicine & Acupuncture

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Pediatric Intake Form

Welcome! It is our goal to provide your child with the best possible complementary natural health care. In order to serve you optimally, please answer the following questions about your child. Thank you!

Child's Name _____ Date _____
Address _____ Zip _____
Birthdate _____ Age _____ Female Male Home Phone _____
Names: Parent 1 _____ Mother Father (Cell #) _____
Parent 2 _____ Mother Father (Cell#) _____
Parent Email: _____ Other Guardian _____
How did hear about this clinic _____ Referred By _____
Person to be notified in case of an emergency _____
Relationship _____ Phone _____
Address _____

List (1) all health problem(s) that are the reason for this appointment, (2) other health concerns:

1. _____
2. _____
3. _____
4. _____
5. _____

Does your child have a contagious illness at this time? Y N If yes, what? _____

Is your child allergic or hypersensitive to any of the following (answer Y or N and list known specifics):

Drugs/Medication Y N _____

Environmentals Y N _____ Worst Season(s) _____

Foods Y N _____

Medications:	Now	Past	Frequency	Supplements:	Now	Past	Dose
Aspirin	_____	_____	_____	Vitamins	_____	_____	_____
Tylenol	_____	_____	_____	Minerals	_____	_____	_____
Antibiotics	_____	_____	_____	Fluoride	_____	_____	_____
Decongestants	_____	_____	_____	Herbs	_____	_____	_____
Other	_____	_____	_____	Other	_____	_____	_____

Childhood Illnesses Y (yes) N (no)

_____ Chicken Pox	_____ Scarlet Fever	_____ Mononucleosis
_____ Measles	_____ Rheumatic Fever	_____ Ear Infections
_____ Mumps	_____ Strep Throat	_____ Tonsillitis

Prenatal/Birth/Feeding History

1. Mother's health during pregnancy for this child (check, then describe below)

____ Age ____ Trauma/Injury ____ Alcohol Consumption #/wk ____
____ Bleeding ____ Stress ____ Drugs ____ Medications
____ Nausea ____ High Blood Pressure ____ Smoking Other ____
____ Illness ____ X-Rays ____ Toxemia

2. Term: Full ____ Premature ____ Late ____ Birth Weight ____

3. Was pregnancy easy? ____ Difficult? ____

Explain _____

4. Place of birth? Hospital ____ Home ____ Clinic ____ Other _____

5. Interventions at labor/birth:

____ Pitocin ____ Epidural ____ Demerol or other pain Rx

____ Forceps ____ C-Section ____ Vacuum extraction

6. Feeding: Breast fed Y N How long? ____ Cow's milk Y N How long? _____

 Formula fed Y N How long? _____ Type of formula _____

7. Age Solid Food Begun ____ What foods? _____

 Favorite Foods _____

8. Sample Daily Diet: (choose a typical day and include food and liquids)

Breakfast

Lunch

Dinner

Snack

Social History:

1. Parents: Married ____ Partnership ____ Separated ____ Single ____ Divorced ____

 Parent's Occupation _____ Full / Part Time

 Parent's Occupation _____ Full / Part Time

2. Other Guardian _____ Relationship _____

3. Others residing in home _____ Relationship _____

4. Daycare/Preschool/School _____ Where _____

 How many hours each day _____ Days of the week _____

5. Pets at home: _____

SIBLING(S): NAME

AGE

HEALTH PROBLEMS

1.

2.

3.

4.

REVIEW OF SYSTEMS

Y: a condition now P: a condition of the past N: Never

MENTAL/EMOTIONAL

Mood Swings	Y	P	N	Anxiety/nervousness	Y	P	N
Irritability	Y	P	N	Cries easily	Y	P	N
Hyperactivity	Y	P	N	Unusual fears	Y	P	N
Introvert/extrovert	Y	P	N	Sleep Problems	Y	P	N
Motion/car sickness	Y	P	N	Nightmares	Y	P	N

ENDOCRINE

Heat/cold intolerance	Y	P	N	Fatigue	Y	P	N
Excessive thirst	Y	P	N	Excessive hunger	Y	P	N
Low blood sugar	Y	P	N	High blood sugar	Y	P	N

SKIN

Rashes	Y	P	N	Eczema, Hives	Y	P	N
Acne, Boils	Y	P	N	Itching	Y	P	N

HEAD

Headaches	Y	P	N	Head Injury	Y	P	N
Dizzy spells	Y	P	N	High fevers	Y	P	N

EYES

Glasses or contacts	Y	P	N	Tearing or dryness	Y	P	N
Eye pain/strain	Y	P	N				

EARS

Earaches	Y	P	N	Impaired hearing	Y	P	N
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NOSE AND SINUSES

Frequent colds	Y	P	N	Noses Bleeds	Y	P	N
Stuffiness	Y	P	N	Hay fever	Y	P	N
Sinus problems	Y	P	N	Loss of smell	Y	P	N

MOUTH AND THROAT

Frequent sore throat	Y	P	N	Canker sores	Y	P	N
Breath odor		Y	P	N			

RESPIRATORY

Cough	Y	P	N	Wheezing	Y	P	N
Asthma	Y	P	N	Bronchitis	Y	P	N

CARDIOVASCULAR

Heart disease	Y	P	N	Murmurs	Y	P	N
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URINARY

Frequent urination	Y	P	N	Bed wetting	Y	P	N
Kidney disease	Y	P	N	Bladder infections	Y	P	N

Y= condition now P= a condition in the past N= never had

GASTROINTESTINAL

Belching/passing gas	Y P N	Stomach aches	Y P N
Constipation	Y P N	Diarrhea	Y P N
Bowel Movements	How often _____		

MUSCULOSKELETAL

Joint pain/stiffness	Y P N	Muscle spasms/cramps	Y P N
Broken bones	Y P N		

BLOOD/PERIPHERAL VASCULAR

Anemia	Y P N	Easy bleeding/bruising	Y P N
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Do you have any other health concerns you would like to discuss? Please explain

Is there any information about your child's health that you would like to add?

Welcome! We're glad to be of service for you and your child!