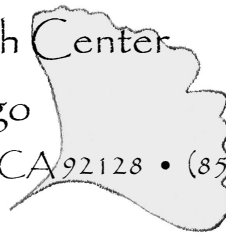


Naturopathic Health Center of San Diego

11650 Iberia Place Suite 136 • San Diego, CA 92128 • (858)442-7100



Confidential Patient Information

Pediatric Intake form to be filled out by parent or legal guardian Date: _____

Child's full name _____ Prefers to be called _____

Sex: Male Female (circle one) Date of birth: _____ Age _____

Street Address : _____

City: _____ State: _____ Zip: _____

Parents/Guardians (address and phone number if different from above). Please indicate with a check mark which phone numbers we can leave a message for you, identifying ourselves by the clinic name or doctor's name

Name _____ Name _____

Address _____ Address _____

Home Phone (____) _____ Home Phone (____) _____

Work (____) _____ Work (____) _____

Other (____) _____ Other (____) _____

In case of emergency, and neither parent can be reached, contact:

Name _____ Relationship: _____

Contact Numbers: _____

Pediatrician Name: _____ Office Number: (____) _____

Can we contact if we need to? Yes No

Are there any other health care providers your child sees? _____

How did you learn about our clinic? _____

Major Complaint

What brings you in for this initial visit? If a diagnosis was made, please indicate date of diagnosis and who or where it was diagnosed.

Date of last complete check up: _____

Are there any other areas you would like to work on?

How would you rate the General Health of your child: (1 being poor, 10 being excellent)

poor 1 2 3 4 5 6 7 8 9 10 excellent

Is your child on any Medications, Homeopathics or Supplements (including vitamins and herbs). Please list dosages

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Any Allergies to medications? _____

Allergies to other substances (foods/inhalents)? _____

How was the pregnancy and childbirth for birth mom? _____

Any difficulties for child following birth? _____

Has your child experienced any major childhood illnesses, accidents, hospitalizations or surgeries? (Please include dates and child's age at the time)

Immunizations and dates if known

DTP _____ Hepatitis B _____
Polio _____ MMR _____
HbCV _____ Chickenpox (Varicella) _____
Other _____

Siblings

Name _____ Age _____ General health: Poor Fair Good
Name _____ Age _____ General health: Poor Fair Good
Name _____ Age _____ General health: Poor Fair Good

What are some of your child's favorite activities/ hobbies:

Does your child have any fears? _____

What are your child's favorite foods and how often are they eaten?

What type of pets do you own? _____

Does anyone in the house smoke? Yes No

How many hours of TV/video games/computer games does your child engage in daily? _____

How would you rate your child's academic performance (if appropriate)

poor fair good excellent

Is there anything else you feel we should know about your child? _____

Please Turn Over to Complete Family Health History on Back

Family History: check all that apply, and indicate family member's relation to you (i.e. maternal aunt).

If family member has passed away from any of the following, please indicate their approximate age at the time of their passing.

Diabetes _____

Heart disease _____

Stroke _____

Heart Attack _____

Alzheimer's disease _____

Other neurological disease(indicate) _____

Hypertension _____

High Cholesterol _____

Osteoporosis _____

Cancer(Type) _____

Chronic Gastrointestinal Disease (i.e. Crohn's Disease, Ulcerative Colitis, Peptic Ulcers, Reflux)
Indicate which of the above or any other _____

Asthma _____

Emphysema (or other chronic respiratory disorder) _____

Chronic Skin condition (i.e. Psoriasis, eczema, rosacea) _____

Alcoholism _____

Depression _____

