

# Alison Finger, ND

Naturopathic Physician

215-348-8470

Doylestown Natural Medicine Center

148 E. State St. 2<sup>nd</sup> Floor

Doylestown, PA 18901

## PEDIATRIC INTAKE FORM (6-12 years)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Female: \_\_\_\_ Male: \_\_\_\_

Mother's name: \_\_\_\_\_ Father's name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone # (home): (\_\_\_\_) \_\_\_\_\_ Parent's # (work): (\_\_\_\_) \_\_\_\_\_

Parent's e-mail address: \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

### HEALTH HISTORY QUESTIONNAIRE

What are your child's most important health problems? List as many as you can in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

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

If yes, what? \_\_\_\_\_

### Previous Illnesses

Rheumatic fever	Y N	German measles	Y N
Chicken pox	Y N	Measles	Y N
Tonsillitis	Y N	approx. number	_____
Ear infections	Y N	approx. number	_____
Other	Y N	list	_____

**PLEASE FILL OUT BOTH SIDES OF EACH PAGE**

Has your child had any of the following tests? When Where  
Electroencephalogram (EEG)

.....  
Psychological evaluation

.....  
Hearing tests

.....  
Speech/Language tests

**Hospitalizations/ Surgeries/ Injuries**

What hospitalizations, surgeries or injuries has your child had?  
\_\_\_\_\_  
\_\_\_\_\_

**Immunizations**

Polio	Y N	Pertussis	Y N
Tetanus shot	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Influenza	Y N
Any adverse reactions?	Y N	If yes, what ?	_____

**Allergies**

Is your child hypersensitive or allergic to:  
Any drugs? \_\_\_\_\_  
Any foods? \_\_\_\_\_  
Any environmental? \_\_\_\_\_  
Breast fed? \_\_\_\_\_ how long? \_\_\_\_\_ Formula? \_\_\_\_\_ milk / soy \_\_\_\_\_

**Typical Food Intake**

Breakfast: \_\_\_\_\_  
Lunch: \_\_\_\_\_  
Dinner: \_\_\_\_\_  
Snacks: \_\_\_\_\_  
To Drink: \_\_\_\_\_

Please list **any** prescription medications, over the counter medications, vitamins or other supplements your child is taking:

- |          |          |
|----------|----------|
| 1) _____ | 5) _____ |
| 2) _____ | 6) _____ |
| 3) _____ | 7) _____ |
| 4) _____ | 8) _____ |

## REVIEW OF SYSTEMS

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

### 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
----------	---	---	---	------------------	---	---	---

### NOSE AND SINUSES

Frequent colds	Y	P	N	Nose Bleeds	Y	P	N
Stuffiness	Y	P	N	Hayfever	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
---------------	---	---	---	---------	---	---	---

**URINARY**

Frequent urination      Y P N      Bed wetting      Y P N

**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

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

What expectations do you have for your child from working with our clinic?

Welcome! I'm honored to be of service for you and your child!