Natural Medicine of NH, LLC

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Patient Note:This is a confidential record of your medical history. It will not be released except with your authorization. *Please complete this questionnaire as thoroughly as possible. Mark anything you do not understand with a question mark.*

New Patient Intake Form- Pediatric

Date:_____

Patient's Name:_____

Age:____ Date of Birth:_____/_____/_____ sex: female male

Mother's name:_____ Father's name:_____

Legal guardian name if applicable_____

Address:_____

City:_____ State:_____ Zip_____

Home Phone (_____)_____ Work Phone(_____)_____

How did you hear about this clinic? _____

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

If yes, what? _____

Medical Concerns – What are the top concerns that you would like addressed?

1) _____

2) _____

3) _____

Previous Illnesses

___ Rheumatic fever ___German measles ___Measles ___Tonsillitis: approx. #_____
___Ear infections: approx. number _____
□ Other: list_____

Has your child had any of the following tests?

Electroencephalogram (EEG): **Y or N**
Psychological evaluation: **Y or N**
Hearing tests Speech/Language tests: **Y or N**

Hospitalizations/ Surgeries/ Injuries:

_____
_____
_____

Immunizations

___Polio ___ Pertussis ___Tetanus shot ___Diphtheria
___ Measles/Mumps/Rubella ___Influenza ___Chicken pox

Any adverse reactions? **Yor N** If yes, what?_____

Allergies

Allergies or hypersensitivities to drugs? **Please list below**

Foods? **List here** _____
Environmental? **List here** _____
Breast fed? ____ How long? _____ Formula? ____ Milk / soy

Typical Food Intake

Breakfast:_____
Lunch:_____
Dinner:_____
Snacks:_____
Beverages_____

Prescription or over the counter medications, Vitamins or other Supplements

1)_____
2)_____
3)_____
4)_____
5)_____
6)_____

REVIEW OF SYSTEMS

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

MENTAL/ EMOTIONAL

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

ENDOCRINE

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

SKIN

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

HEAD

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

EYES

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

EARS

Earaches.....Y P N
Impaired hearing.....Y P N

NOSE AND SINUSES

Frequent colds.....Y P N
Stuffiness.....…Y P N
Sinus problems.....Y P N
Nose Bleeds.....Y P N
Hayfever.....Y P N
Loss of smell.....….Y P N

MOUTH AND THROAT

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

RESPIRATORY

Cough.....Y P N
Asthma.....Y P N
Wheezing.....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
Constipation..... Y P N
Bowel Movements.....Y P N
Stomach aches.....Y P N
Diarrhea.....Y P N
How often:_____

MUSCULOSKELETAL

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

_____
_____
_____
_____
_____