



# Whole Health Concord

Naturopathic Medical Center

Dr. Laura Riley

## Pediatric Intake Form

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex: M  F

Grade of School: \_\_\_\_\_

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

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

Mother's Name and occupation: \_\_\_\_\_

Father's Name and occupation: \_\_\_\_\_

Parents are:  Married  Separated  Divorced  Living Together  Other

Insurance Company: \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Regular Pediatrician name and city located in: \_\_\_\_\_

Reason for Office Visit: \_\_\_\_\_

Has child been seen by any other doctor(s) for this complaint? Yes No Past

Has child had any blood work done? If yes, please list what:

\_\_\_\_\_

Please list any operations or hospitalizations and year occurred:

- 1.
- 2.
- 3.

Please list all medicines (from drugstore or prescription) child is on now:

- 1.
- 2.
- 3.
- 4.

Please list all supplements child is taking:

- 1.
- 2.
- 3.
- 4.

Any known Allergies to food, drugs, environment, animals: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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114 S. State Street ♦ Concord, NH 03301 ♦ [www.naturalmedicinenh.com](http://www.naturalmedicinenh.com) ♦ 603.369-4626



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## Previous medical history

**Yes** indicates the child gets the problem regularly; **No** indicates the child never had the problem; **Past** indicates the child had the problem in the past but not recently. Please circle the correct one for your child.

Ear Infections? Yes  No  Past  If has had, how many total? \_\_\_\_\_

Colds? Yes  No  Past  If has had, how many total? \_\_\_\_\_

Strep throat? Yes  No  Past  If has had, how many total? \_\_\_\_\_

How many times has the child taken antibiotics: \_\_\_\_\_

What other medicines has the child taken? And how often?

- 1.
- 2.
- 3.
- 4.

Hearing tests Normal: Yes  No  Not Tested

Vision Tests Normal: Yes  No  Not Tested

Any speech impediments: Yes  No  Past

Learning impediments: Yes  No  Don't know

**Vaccination History:** **Yes**, has had; **No**, has not; **Some**, did not finish all shots

**MMR:** Yes  No  Some  **DPT:** Yes  No  Some

**Hep B:** Yes  No  Some  **Hib:** Yes  No  Some

**Chickenpox:** Yes  No  Some  **Polio:** Yes  No  Some

Other: \_\_\_\_\_

Any reactions to vaccinations? If so, please explain: \_\_\_\_\_

## Family history

Allergies: Yes  No  Obesity: Yes  No

Cancer: Yes  No  Tuberculosis: Yes  No

Cardiovascular disease: Yes  No  Mental Illness: Yes  No

Diabetes mellitus: Yes  No

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## Mother's Pregnancy history

Age at conception: \_\_\_\_\_

Did she have other children already? Yes  No

## Health During Pregnancy

Smoking: Yes  No

Diabetes: Yes  No

Coffee: Yes  No

Nausea/Vomiting: Yes  No

Recreational drugs: Yes  No

Emotional Stress: Yes  No

Preeclampsia: Yes  No

Length of Labor: \_\_\_\_\_

Vaginal birth: Yes  No

Traumatic birth: Yes  No

If the birth was difficult, please explain:

\_\_\_\_\_

Health of baby at birth: \_\_\_\_\_

Child breastfed: Yes No For how long: \_\_\_\_\_

When put on formula: \_\_\_\_\_ What formula was used: \_\_\_\_\_

When was child put on solid food: \_\_\_\_\_

When did child walk: \_\_\_\_\_ Talk: \_\_\_\_\_

When did child develop teeth: \_\_\_\_\_

## Health History of child

Jaundice as baby: Yes  No

Poor teeth: Yes  No

Colic: Yes  No

Tantrums: Yes  No

Cradle cap: Yes  No

Chronic sniffles: Yes  No

Anemia: Yes  No

Disobedient: Yes  No

Eczema or psoriasis: Yes  No

Bad foot odor: Yes  No

Asthma: Yes  No

Fears/Phobia: Yes  No

Diarrhea: Yes  No

Very sweaty baby/child: Yes  No

Warts: Yes  No

Diaper Rash: Yes  No

Constipation: Yes  No

Hyperactivity: Yes  No

Nightmares: Yes  No

Early Puberty: Yes  No

Finicky eating: Yes  No

Growing pains: Yes  No

Bed-wetting: Yes  No

Stomach Aches: Yes  No

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## Any particular household stressors child has witnessed or gone through:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## Typical Day's Diet:

Breakfast: \_\_\_\_\_

Snack: \_\_\_\_\_

Lunch: \_\_\_\_\_

Snack: \_\_\_\_\_

Supper: \_\_\_\_\_

Snack: \_\_\_\_\_

## Toxin Exposure:

Has the child ever lived near a refinery or other highly polluted area? \_\_\_\_\_

Has the child ever lived in a house with lead paint? \_\_\_\_\_

Has the child ever lived in a house that had new paint, cabinets, carpeting installed and did that seem to affect their health at all? \_\_\_\_\_

Do you spray pesticides or herbicides around the house or use other toxic chemicals?

\_\_\_\_\_

Does the child seem particularly sensitive to perfumes or other vapors? \_\_\_\_\_

## Additional Comments: