



Whole Health Concord

Naturopathic Medical Center
Dr. Laura Riley Jones

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 (circle): Married Separated Divorced Living Together Other

Pediatrician name and city located in: _____

Please list your child's health concerns:

1. _____
2. _____
3. _____

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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314 S. Main St. * Concord, NH 03301 * 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 NoPast If has had, how many total? _____

Colds? Yes NoPast If has had, how many total? _____

Strep throat? Yes NoPast 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 NoSome DPT: Yes No Some

Hep B: Yes NoSome Hib: Yes No Some
Polio

Chickenpox: Yes No Some : 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

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:

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