



# PEARL NATURAL HEALTH

## PEDIATRIC INTAKE FORM (BIRTH TO 5 YEARS)

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: Female / Male  
 Parent/Guardian's Name: \_\_\_\_\_ Insurance Plan: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone (home): \_\_\_\_\_ (Parent's work): \_\_\_\_\_  
 Parent's email address: \_\_\_\_\_  
 How did you hear about this clinic? \_\_\_\_\_  
 Has any other family member already been a patient at this clinic? \_\_\_\_\_  
 Name of doctor's office/hospital/clinic where your child's health records are kept: \_\_\_\_\_  
 \_\_\_\_\_  
 Reason for referral or presenting problems: \_\_\_\_\_  
 \_\_\_\_\_

### MEDICATIONS

NOW	PAST	NOW	PAST
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Aspirin  
 Tylenol  
 Antibiotics  
 Ibuprofen  
 Decongestants  
 Anti-histamine  
 Other \_\_\_\_\_  
 Allergies to medicines: \_\_\_\_\_

### MEDICAL HISTORY

\_\_\_\_\_ Chicken pox \_\_\_\_\_ Scarlet fever \_\_\_\_\_ Tonsillitis, approx no. of times: \_\_\_\_\_  
 \_\_\_\_\_ Measles \_\_\_\_\_ Pneumonia \_\_\_\_\_ Ear infections, approx no. of times: \_\_\_\_\_  
 \_\_\_\_\_ Mumps \_\_\_\_\_ Frequent colds \_\_\_\_\_ Strep throat, approx no. of times: \_\_\_\_\_  
 \_\_\_\_\_ Rubella \_\_\_\_\_ Rheumatic fever \_\_\_\_\_ Other: \_\_\_\_\_

### Has your child ever had any of the following? WHEN WHERE RESULTS

Electroencephalogram (EEG): \_\_\_\_\_  
 Psychological evaluations: \_\_\_\_\_  
 Hearing test: \_\_\_\_\_  
 Speech/language tests: \_\_\_\_\_  
 Injuries/surgeries/hospitalizations (please list): \_\_\_\_\_  
 \_\_\_\_\_

### IMMUNIZATIONS

\_\_\_\_\_ MMR \_\_\_\_\_ DPT \_\_\_\_\_ Chicken pox Others: \_\_\_\_\_  
 \_\_\_\_\_ Measles \_\_\_\_\_ Diphtheria \_\_\_\_\_ Small pox Adverse reactions: Y / N  
 \_\_\_\_\_ Mumps \_\_\_\_\_ Tetanus \_\_\_\_\_ H. influenza If so, what? \_\_\_\_\_  
 \_\_\_\_\_ Rubella \_\_\_\_\_ Polio \_\_\_\_\_ The flu \_\_\_\_\_

### FAMILY HISTORY

\_\_\_\_\_ Heart disease \_\_\_\_\_ Diabetes \_\_\_\_\_ Birth defects  
 \_\_\_\_\_ Hypertension \_\_\_\_\_ Arthritis \_\_\_\_\_ Tuberculosis  
 \_\_\_\_\_ Cancer \_\_\_\_\_ Allergies \_\_\_\_\_ Asthma  
 \_\_\_\_\_ Mental illness \_\_\_\_\_ Osteoporosis \_\_\_\_\_ Other significant: \_\_\_\_\_

**PRENATAL HISTORY**

Previous pregnancies by natural mother, miscarriages, or complications? \_\_\_\_\_

Mother's age at child's birth: \_\_\_\_\_

Mother's health during pregnancy:

- \_\_\_\_ Bleeding \_\_\_\_ Nausea \_\_\_\_ Physical or emotional trauma
- \_\_\_\_ Illnesses \_\_\_\_ Hypertension \_\_\_\_ Cigarettes, alcohol, drug consumption
- \_\_\_\_ Medications \_\_\_\_ Diabetes \_\_\_\_ Thyroid problems

**BIRTH HISTORY**

Term: \_\_\_\_ Full \_\_\_\_ Premature \_\_\_\_ Late Weight at birth: \_\_\_\_\_

Length of labor: \_\_\_\_\_ Complications: \_\_\_\_\_

Did you child have any of the following problems shortly after birth?

- \_\_\_\_ Rashes \_\_\_\_ Birth injuries \_\_\_\_ Blue baby
- \_\_\_\_ Jaundice \_\_\_\_ Seizures \_\_\_\_ Cerebral palsy
- \_\_\_\_ Colic \_\_\_\_ Fever \_\_\_\_ Birth defects
- \_\_\_\_ Other: \_\_\_\_\_

Child's sleep patterns (1st year): \_\_\_\_\_

Food intolerances: \_\_\_\_\_

Breast fed: Y / N How long: \_\_\_\_\_ Formula: Y / N Type (milk, soy): \_\_\_\_\_

Age began solids: \_\_\_\_\_ Which foods: \_\_\_\_\_

Age began: Sitting \_\_\_\_\_ Crawling \_\_\_\_\_ Walking \_\_\_\_\_ Talking \_\_\_\_\_

**SYMPTOMS**

- \_\_\_\_ Hives \_\_\_\_ Burning urine \_\_\_\_ Bloody urine \_\_\_\_ Eczema
- \_\_\_\_ Cries easily \_\_\_\_ Bleeding gums \_\_\_\_ Heart murmur \_\_\_\_ Nervous
- \_\_\_\_ Nose bleeds \_\_\_\_ Vomiting spells \_\_\_\_ Sleep problems \_\_\_\_ Asthma
- \_\_\_\_ Acne \_\_\_\_ Anemia \_\_\_\_ Night sweats \_\_\_\_ High fevers
- \_\_\_\_ Jaundice \_\_\_\_ Sensitive to light \_\_\_\_ Chronic rash \_\_\_\_ Stomach aches
- \_\_\_\_ Diarrhea \_\_\_\_ Hearing loss \_\_\_\_ Easy bruising \_\_\_\_ Sore throats
- \_\_\_\_ Flat feet \_\_\_\_ No appetite \_\_\_\_ Body/breath odor \_\_\_\_ Constipation
- \_\_\_\_ Nightmares \_\_\_\_ Frequent colds \_\_\_\_ Bleeding tendency \_\_\_\_ Unusual fears
- \_\_\_\_ Wheezing \_\_\_\_ Joint pains \_\_\_\_ Excessive fatigue \_\_\_\_ Cough
- \_\_\_\_ Dizzy spells \_\_\_\_ Hair loss \_\_\_\_ Frequent urination \_\_\_\_ Allergies

**DIET**

Please describe your child's typical daily diet:

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

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

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

To drink: \_\_\_\_\_

**Thank you for your time and effort. We look forward to providing you with the best possible care. If there is anything else you would like to add at this time please do so on the back of this page or another sheet of paper.**