CENTRE DOWNE HEALTH LLC

Naturopathic Family Medicine and Acupuncture

Dr. Brian Paterson, ND, Lac and Dr. Kathryn Cranford, ND, NHCM

PEDIATRIC INTAKE FORM

All contact information is for professional use only and will be held in strict confidence.

Patient's Name _____

Patient's Date of Birth _____/_____/_____ Age: _____ Gender M _____ F _____

Home Street address: _____

City: _____ State: _____ ZIP: _____

Mother's Name _____ Contact phone_____

Father's Name _____ Contact phone_____

Family email:_____ I would like to receive WHHA e-newsletters Y N

Medical Concerns (in order of importance):

1.) _____ 3.) _____

2.) _____ 4.) _____

Medications	Now	Past
Antibiotics	_____	_____
Antihistamine	_____	_____
Aspirin	_____	_____
Decongestant	_____	_____
Ibuprofen	_____	_____
Tylenol	_____	_____

Other Medications:

_____

_____

Allergies to medication: List drug and type of reaction:

_____

_____

_____

Any known food/environmental allergies:

_____

_____

Injuries / Surgeries / Hospitalizations:

_____

_____

CHILDHOOD DISEASES: Has your child had:			**Vaccinated?**	
Condition had?	**# of times**	**Had disease? Y or N or ?= not sure**	**Yes**	**No**
ADD/ADHD Y N		Chicken Pox (Varicella) ? Y N		
Allergies Y N		Diphtheria (DTaP) ? Y N		
Asthma Y N		H-influenza (Hib) ? Y N		
Bronchitis Y N		HPV (Gardasil) ? Y N		
Ear Infections Y N		Measles (MMR) ? Y N		
Eczema Y N		Mumps (MMR) ? Y N		
Strep Throat Y N		Pertussis (DTaP) ? Y N		
Tonsillitis Y N		Polio (IPV) ? Y N		
		Rotavirus (Rota) ? Y N		
		Rubella (MMR) ? Y N		
		Scarlet Fever-strep A ? Y N		
		Tetanus (DTaP) ? Y N		

Has your child had any of the following tests? When Where Results

Electroencephalogram _____

Psychological evaluation _____

Hearing _____

Speech / Language _____

Vision _____

Family History:

_____ Allergies _____ Cancer _____ Hypoglycemia _____ Mental illness

_____ Arthritis _____ Diabetes _____ Heart disease _____ Tuberculosis

_____ Birth defects _____ Hepatitis _____ Hypertension Other:_____

Mother's Pregnancy Health History:

Pregnancies by birth mother: _____ Miscarriages or complications:_____

Mother's general health during pregnancy:_____

_____ Bleeding _____ Extreme nausea _____ Gestational Diabetes _____ Thyroid

_____ Hypertension _____ Physical trauma _____ emotional trauma _____ Illness

_____ Cigarettes, alcohol, drug consumption: which/how much _____

Mother's age at childbirth: _____ Birth Medications (please list):_____

Birth History:

Term: Pre-term: _____ Full-term: _____ Post-dates: _____ Weight at birth: _____lbs._____ oz.

Length of labor: _____ Complications?:_____

Has your child had any of the following problems:

_____ Allergies _____ Blue baby _____ Diarrhea _____ Rashes

_____ Birth defects _____ Cerebral palsy _____ Fever _____ Seizures

_____ Birth injuries _____ Colic _____ Jaundice _____ other

Child's approximate sleep patterns (first year): _____

Feeding: Breast fed: _____ for how long?:_____ Formula:_____ milk / soy / other

Age began: Solid Foods:_____ Sitting:_____ Crawling: _____Walking: _____First Words: _____

Please describe your child's typical diet: Intake and Output

Breakfast: _____ Mid AM Snack: _____

Lunch: _____ Mid PM Snack: _____

Dinner: _____ Late PM Snack/dessert: _____

Fluid intake daily (type & amount)_____

Urination/day_____ # Bowel Movement/day _____ color: _____ Blood: Y N Mucus: Y N

Symptoms List:

Now	Past		Now	Past		Now	Past	
_____	_____	Acne	_____	_____	Eczema	_____	_____	Muscle/bone pain
_____	_____	Anemia	_____	_____	Excessive fatigue	_____	_____	Nervousness
_____	_____	Bleeding gums	_____	_____	Flat feet	_____	_____	Night sweats
_____	_____	Bleeding tendency	_____	_____	Frequent colds	_____	_____	Nightmares
_____	_____	Bloody urine	_____	_____	Frequent headache	_____	_____	Nose bleeds
_____	_____	Body / breath odor	_____	_____	Gas, colic	_____	_____	Runny nose
_____	_____	Burning urination	_____	_____	Hay fever	_____	_____	Sensitive to light
_____	_____	Canker sores	_____	_____	Hair loss	_____	_____	Sleep problems
_____	_____	Chronic rash	_____	_____	Hearing loss	_____	_____	Sore throats
_____	_____	Constipation	_____	_____	Heart murmur	_____	_____	Stomach aches
_____	_____	Cough	_____	_____	Hives	_____	_____	Teeth problems
_____	_____	Cries easily	_____	_____	Jaundice	_____	_____	Unusual fears
_____	_____	Dizzy spells	_____	_____	Joint pains	_____	_____	Vomiting spells
_____	_____	Diarrhea	_____	_____	Lack of appetite	_____	_____	Wheezing
_____	_____	Easy bruising	_____	_____	Motion sickness	Other: _____		

What makes your child the happiest? _____

Any fears or phobias? _____

Anything else you'd like me to know about your child as an individual or a patient?

_____
_____
_____
_____
_____
_____
_____
_____

www.CentreDowneHealth.com
office phone: (603) 524-9261
203 Pickerel Pond Rd. Laconia, NH 03246
fax: (603)-279-8870