Family Tree Medicine
Pediatric Intake

Name______________________________ Date of Birth__________________________
Date______________________________ Age___________________________________
Mother's Name_____________________ Mothers Occupation___________________
Father's Name_____________________ Fathers Occupation___________________
Legal Guardian____________________ Referred by__________________________
Name and Relationship of person filling out form_________________________________

Address____
(Street) (city) (state) (zip)

Phone # Home_________________ Work__________________Cell_________________

Childs Main Health Concerns:

1.____
2.____
3.____
4.____

Does your child have any dietary restrictions?___________________________________

Early Life History:

Mother's Pregnancy

Uncomplicated Early Labor Excessive Vomiting Bleeding Diabetes
Thyroid Problems Trauma High Blood Pressure Smoking Alcohol Use
Drug Use Other____
Medications during Pregnancy____
Supplements during Pregnancy____

Birth History

Birth weight___________ Weeks__________ Mother's age at birth_________
Full Term Premature Past Term
Vaginal C-Section -Reason:___________________________________
Birth Complications or interventions____

Post-Natal Complications

None Jaundice Respiratory Cardiac
Infections Gastrointestinal Birth Defects Birth Injuries

Nursing

Was the child breastfed?___________ If so, how long? _____________________________
Difficulty nursing? ____
Formula used?_________ If so, at what age? ___________________________________
When were solids introduced?_________ First Foods:______________________________

Immunizations

Is the child vaccinated? Yes No If yes, were boosters given? Yes No
Please check which vaccines given:

Hep B DTP Polio HiB Pneumococcal MMR
Hep A Varicella Rotavirus Influenza Meningococcal

Any adverse reactions noted?____
____
Has the child had any of the conditions listed above?______________________________
____

Family Medical History

Indicate where applicable.
Was the child adopted? Yes No

	Mother	Father	Sisters	Brothers	Grandmother	Grandfather
Allergies						
Anemia						
Asthma						
ADHD						
Birth Defects						
Cancer						
Celiac Disease						
Cystic Fibrosis						
Diabetes						
Depression						
Eczema						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Learning Disability						
Mental Illness						
Multiple Sclerosis						
Rheumatoid Arthritis						
Seizures						
Stroke						
Tuberculosis						

Other____

General Health History

Describe this child's general state of health: Poor Fair Good Excellent

Have there been any serious conditions, illnesses or injuries or hospitalizations?
Yes No

If yes, please describe and include approximate dates:

____
____
____

How many times has this child been treated with antibiotics?_____________________

Does this child have any allergies (food, medicine, environmental, etc,)?

____
____

List all current supplements and medications (over the counter, prescription, vitamins, herbs, homeopathics, etc.):

____
____
____

List past prescription medications:

____
____

Interaction with other children: Very Good Average Poor

Behavior: Excellent Variable Disruptive

Activities this child enjoys:

____
____

Regular foods in Diet:

____
____
____

Number of Bowel movements per day:____

Describe this child's sleep habits:

Symptoms and Diagnosis (Please check for current, or use "P" for past symptom)

Acne		Excessive Gas	
Asthma		Fevers	
Abdominal Pain		Fatigue	
Allergies		Frequent Urination	
Anemia		Headaches	
ADHD		Hearing Problems	
Anxiety		Hives/Itching	
Autism		Indigestion	
Blood in Stool		Irritability	
Blood in Urine		Jaw Clicks or Pain	
Bronchitis		Lack of Coordination	
Bed Wetting		Loss of Balance	
Bleeds/Bruises Easily		Loss of Hair	
Body/Breath Odor		Lumps, swollen glands	
Blurry Vision		Mercury Fillings	
Chills		Memory Problems	
Change in Appetite/Thirst		Motion Sickness	
Cravings		Muscle or joint pain	
Cough		Mood Changes	
Constipation		Nose Bleeds	
Cries Easily		Neck Pain	
Cradle Cap		Nausea	
Diabetes		Nightmares	
Diarrhea		Pain on Urination	
Dry Skin		Rashes	
Difficulty Breathing		Ringing in Ears	
Dizziness		Sore Throat	
Earache/Infections		Vision Problems	
Eczema		Vomiting	
Excessive Sweating		Weight Changes	

Please describe any other problems you would like to discuss: