Vashon Natural Medicine

Homegrown healthcare since 1998

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Pediatric Intake Form

Date of Birth ____ / ____ / ____ Age________ Gender ______ Grade _____ Current School _________________

Last Name ____________________________________ First Name _________________________ M.I. ________

Mailing Address ____

City _________________________ State _______ Zip ____________ Home Phone ______________________

Emergency Contact ________________________ Phone _______________ Relationship ___________________

Mother's full name ___________________ Father's full name __________________ Guardian ________________

Primary health concern Secondary concern

____

Birth History

Mothers' age at child's birth ____________ Prolonged Labor ___________ Surgical intervention _______________

Adopted? Yes No From country: ____________ Mother's health during pregnancy (please check all that apply): ____Bleeding ____Hypertension ____ Illness ____Nicotine Use _____Alcohol use ____Drug Use ____Nausea ____Diabetes ____Thyroid problems ____Physical or emotional trauma _____ Bed ridden _____

Other (explain) ____

Name of last doctor _________________________________ Date of last Physical _______________________

Hospitalizations Year Reason Year Reason

____

Surgeries Year Reason Year Reason

____

Current Medications

Prescription

____

Non-Prescription

____

Diet

Does your child follow a special diet? __________ *yes, explain*

____

Exercise

Type ___________________________________ Number of Times per week _______ For how long? __________

Health History

	If yes, please list date and details
1. Had any recent injury, illness or infectious disease?	
2. Have a chronic or recurring illness/condition?	
3. Ever been hospitalized or had surgery?	
4. Have frequent headaches?	
5. Ever had a head injury?	
6. Ever had frequent ear infections?	
7. Ever been dizzy or passed out during or after exercise? Chest pain during or after exercise?	
8. Ever been diagnosed with a heart murmur?	
9. Ever had problems with joints (e.g., knees, ankles)?	
10. Have any skin problems (e.g., itching, rash, acne)?	
11. Have diabetes?	
12. Have asthma?	
13. Had problems with diarrhea/constipation?	
14. If female, have an abnormal menstrual history?	
15. Ever had an eating disorder?	
16. Ever had emotional difficulties for which professional help was sought?	

Medical History – Which of the following has your child had? Check all that apply

TB Test	German Measles	Measles	Mumps
Scarlet Fever	Diphtheria	Mumps	Ear Infections # of times
Chicken Pox At what age	Rheumatic Fever	Polio	Tonsillitis # of times
Bronchitis	Eczema	Croup	Other
Known Allergies – list			

Immunization History

DTaP						
TD (tetanus/diphtheria)						
Tetanus						
Polio						
HIB						
MMR						
Haemophilus influenza B						
Hepatitis B						
Varicella (chicken pox)						

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