Dr. Kelly Brown, N.D.
Naturopathic Doctor

Good n Natural HEALTH FOOD STORE
Quality Vitamins and Supplements · Natural Body Care and Organic Food
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Pediatric Intake Form

All information included here will be absolutely confidential. If you have any questions please ask. Thank you

Today's Date: _____

Childs Name: _____ Age _____ **M** **F**

Birthdate (M/D/Y): _____

Parents Name: _____

Home Address: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone/Other: _____ Email: _____

Extended Health Insurance Provider: _____

Group/Plan # _____ Contract/ID # _____

Employer/School: _____

Emergency Contact: _____ Phone Number: _____

Name of other Healthcare Providers:

Medical Doctors: _____ Chiropractor: _____

Naturopathic Physician: _____ Other: _____

How did you hear about our clinic? _____

Your Main Health Concern

Why are you bringing your child to the clinic today?

What are your most important health problems? List in order of importance:

1.
2.
3.

Please list all the vitamin/mineral/herb supplements you are taking:

Supplement Dose How long have you been taking this supplement?

Please list all current medications you are taking:

Medication Dose How long have you been taking this medication?

Check each that you currently use: Pain Relievers ☐ Antibiotics ☐ Allergy Medication ☐

Please list any past medications:

Past Medical History (please list any major illnesses or surgeries):

Prenatal History

Mothers age at conception: _____ Health Status (circle) POOR FAIR GOOD EXCELLENT

Fathers age at conception: _____ Health Status (circle) POOR FAIR GOOD EXCELLENT

Any difficulty conceiving? Yes ☐ No☐ If yes, please explain:

_____

_____

Did mother use any of the following during pregnancy?

Tobacco ☐ Alcohol ☐ Prescription drugs ☐ Recreational drugs ☐

Over the counter medications☐ Supplements ☐ Other ☐

Birth History

Weight at birth: _____

Type of delivery:

Vaginal ☐ C-Section ☐ Induced ☐ Forceps ☐

Did child experience any of the following at or after birth?

Jaundice ☐ Rashes ☐ Seizures ☐ Birth injuries ☐

How was your infant fed?

Breast ☐ Formula ☐

For how long? _____

When were solids introduced? _____

What foods were introduced in the first 12 months? _____

Please list any allergies: _____

Family Medical History

Age, Health Problems, If Deceased, Cause of Death, and Age at Death

Father:

Mother:

Brother/Sisters:

Children:

Is your child exposed to any toxins or chemicals in your home or work (mold, chemicals, etc.)?

_____

Has your child been vaccinated? _____

Which vaccinations? _____

Have you travelled recently? Where? _____

How physical active is your child? What type of activities do they do?

_____

Diet (Please complete 1 week food diary attached to form)

Are you or have you ever been on a restricted diet? _____ If so, what kind? _____

_____

How much water do you drink per day? _____

How frequently do you move your bowels? _____

Please check boxes that apply, if symptom is current or recurring problem:

General

Fatigue ☐	Change in appetite ☐	Change in thirst ☐	Cravings ☐
Weight gain ☐	Weight loss ☐	Poor Sleep ☐	Chills or fever ☐
Night sweats ☐	Allergies ☐	Cancer ☐	Diabetes ☐

Skin and Hair

Dryness ☐	Eczema ☐	Psoriasis ☐	Acne ☐
Recent moles ☐	Hives/allergic reactions ☐	Loss of hair ☐	
Thinning of hair ☐	Dandruff ☐	Other skin problems ☐	

Eyes, Ears, Nose and Throat

Eye Pain ☐	Eye strain ☐	Blurry vision ☐	Impaired Vision ☐
Each aches ☐	Ear infections ☐	Ringing in ears ☐	
Vertigo/dizziness ☐	Sinus infections ☐	Nasal Obstructions ☐	Post nasal drip ☐
Nosebleeds ☐	Loss of smell/taste ☐	Sores in mouth ☐	Mercury fillings ☐
Jaws or clicks ☐	Tonsillitis ☐	Recurrent sore throat ☐	Enlarged glands ☐
Enlarged thyroid ☐	Facial pain/tics ☐	Headaches ☐	

Cardiovascular

Chest pain ☐	Palpitations ☐	High/low blood pressure ☐	Irregular heart beat ☐
Fainting ☐	Cold hands/feet ☐	Artificial heart valve ☐	Swelling of limbs ☐
Anemia ☐	Easy bruising ☐		

Respiratory

Asthma ☐	Emphysema ☐	Difficulty breathing ☐	Shortness of breath ☐
Chronic cough ☐	Bronchitis ☐	Wheezing ☐	Coughing blood ☐
Phlegm in throat ☐			

Muscles, bones & Joints

Neck pain ☐	Back pain ☐	Juvenile ☐	Bursitis ☐
Joint pain/stiffness ☐	Artificial joint ☐	Muscle pain ☐	Muscle weakness ☐

Gastrointestinal

Nausea ☐	Vomiting ☐	Vomiting blood ☐	Reflux/Heartburn ☐
Constant hunger ☐	Ulcer ☐	Indigestion ☐	Bloating ☐
Gallbladder ☐	Jaundice ☐	Abdominal pain/cramps ☐	Liver disease ☐
Gas ☐	Constipation ☐	Diarrhea ☐	Intestinal parasites ☐
Hemorrhoids ☐	Blood in stool ☐	Rectal burning/pain ☐	Chronic laxative use ☐

Neurological

Anxiety ☐	Depression ☐	Emotional problems ☐	Irritability☐
Loss of balance ☐	Poor memory ☐	Seizures/epilepsy ☐	Dizziness ☐
Concussions ☐	Extremity tingling ☐	Extremity numbness ☐	Paralysis ☐
Lack of coordination ☐			

Infections

Strep throat ☐	Tuberculosis ☐	Hepatitis ☐	HIV/AIDS ☐
Mononucleosis (Mono) ☐			

Urinary

Blood in urine ☐	Urgency to urinate ☐	Urinary tract infection ☐	Kidney stones ☐

There are some slight risks to treatment by Naturopathic Medicine. These include but are not limited to

- Potential allergic reaction to supplements or herbs
- Some aggravation of pre-existing symptoms as part of healing when using homeopathic remedies

I understand that the Naturopathic Doctor will answer any questions that I have to the best of their ability. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to treatment by my naturopath. I understand this consent form to cover the entire course of my treatment. I understand that I am free to withdraw this consent and to discontinue participation in these procedures at any time.

Patient Name: (please print) _____

Signature or Patient or Guardian: _____

Date: _____

One week food diary

*If still breastfeeding, please have mother fill out the food diary

	Breakfast	Lunch	Supper	Snacks
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				