Sweetgrass
NATURAL MEDICINE

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# PEDIATRIC INTAKE FORM (6-12 YEARS)

## Patient Information

Name: _____ Date of Birth: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Contact Telephone # (home): _____ (Cell): _____ (Work):_____

Age:_____ Date of Birth: _____ M____ F____

Parent's Names:_____

How did you hear about this clinic? _____

## Health History Questionnaire

What are your child's most important health concerns? List as many as you can in order of concern.

1)_____

2)_____

3)_____

4)_____

5)_____

Is your child sick at this time? Y_____ N_____

Was your child breast fed? Y____ N____ Formula? Y____ N____ Kind? _____

## Family History

Does your child have a family history of any of the following?

____ Cancer ____ Diabetes ____ Heart Disease ____ High Blood Pressure

____ Kidney Disease ____ Epilepsy ____ Arthritis ____ Glaucoma

____ Tuberculosis ____ Stroke ____ Anemia ____ Mental Illness

____ Asthma/Hayfever/Hives ____ Alcoholism

Any other relevant family history? _____

_____

What is your child's heritage? _____

## Childhood Illnesses

Please check if your child has had:

____ Scarlet fever ____ Diptheria ____ Rheumatic fever ____ Chicken Pox

____ Mumps ____ Measles ____ German measles ____ Rheumatic fever

____ Ear Infections ____ Strep Throat _____Antibiotics (# of times _____) ____ Other

Any major injuries?_____

Hearing/Speech/Language Tests?_____

## Immunizations

____Polio ____Pertussis ____Measles/mumps/rubella

____tetanus ____diptheria others _____

Any adverse reactions? Y____ N____ If so, explain? _____

## Hospitalizations, Surgery, Imaging

What hospitalizations, surgeries, X-rays, CAT scans, EEGs, EKGs, ultrasounds, has your child had?

_____year:_____ _____year:_____

_____year:_____ _____year:_____

_____year:_____ _____year:_____

## Allergies

Any drugs? _____

Any foods? _____

Any chemicals or environmentals? _____

## Medications

Please list all prescription medications, over the counter medications, vitamins, herbal medicines, and supplements your child takes.

1) _____ 4)_____

2) _____ 5)_____

3) _____ 6)_____

## General

Height: _____ Weight:_____lbs. Weight one year ago: _____lbs.

Maximum weight: _____lbs. When: _____

When is your child's energy the best? _____worst?_____

Rate your child's energy (1-10) _____ Is this a change?_____

How is your child's mood? _____ Is this a change? _____

How is your child's appetite?_____ Is this a change? _____

### Typical food intake:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Cravings: _____

Drinks: _____

## Review of Systems

Y=a condition you have now  P = Significant in the past  N = Never Had

### Mental/Emotional

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Treated for emotional problems? | Y | P | N | Depression? | Y | P | N |
| Anxiety or nervousness? | Y | P | N | Mood swings? | Y | P | N |
| Considered/attempted suicide? | Y | P | N | Eating disorder? | Y | P | N |
| Tension? | Y | P | N | Poor concentration? | Y | P | N |

### Endocrine

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Thyroid problems? | Y | P | N | Heat or cold intolerance? | Y | P | N |
| High or low blood sugar? | Y | P | N | Diabetes? | Y | P | N |
| Excessive thirst? | Y | P | N | Excessive hunger? | Y | P | N |
| Fatigue? | Y | P | N | Seasonal depression? | Y | P | N |
| Cry easily? | Y | P | N | Hair loss? | Y | P | N |

### Immune

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Frequent illnesses? | Y | P | N | Swollen glands? | Y | P | N |
| Slow wound healing? | Y | P | N | Autoimmune disease? | Y | P | N |
| Cancer? | Y | P | N | What type? | | | |

### Neurologic

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Seizures? | Y | P | N | Dizziness/lightheadedness? | Y | P | N |
| Loss of balance? | Y | P | N | Paralysis? | Y | P | N |
| Numbness/tingling? | Y | P | N | Muscle weakness? | Y | P | N |
| Loss of memory? | Y | P | N | Easily stressed? | Y | P | N |

### Skin/Hair/Nails

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Rashes? | Y | P | N | Eczema/hives? | Y | P | N |
| Acne/boils? | Y | P | N | Itching? | Y | P | N |
| Dry/flaky skin or brittle nails? | Y | P | N | Color changes? | Y | P | N |
| Lumps? | Y | P | N | Night sweats? | Y | P | N |

### Head

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Headaches? | Y | P | N | Migraines? | Y | P | N |
| TMJ problems? | Y | P | N | Head injury or concussion? | Y | P | N |

### Eyes

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Blurry vision? | Y | P | N | Double vision? | Y | P | N |
| Spots in the eyes? | Y | P | N | Eye pain/strain? | Y | P | N |
| Color blindness? | Y | P | N | Tearing or Dryness? | | | |

### Ears

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Impaired hearing? | Y | P | N | Ringing? | Y | P | N |
| Dizziness? | Y | P | N | Earaches? | Y | P | N |
| Ear infections? | Y | P | N | Clicking noise on swallowing? | Y | P | N |

### Nose

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Loss of smell? | Y | P | N | Stuffiness? | Y | P | N |
| Sinus problems? | Y | P | N | Frequent colds? | Y | P | N |
| Nose bleeds? | Y | P | N | Hay fever? | Y | P | N |

## Mouth and Throat

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Frequent sore throat? | Y | P | N | Sore lips/tongue? | Y | P | N |
| Copious saliva? | Y | P | N | Hoarseness? | Y | P | N |
| Cavities? | Y | P | N | Gum problems? | Y | P | N |
| Teeth grinding? | Y | P | N | Jaw clicking? | Y | P | N |

## Neck

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Lumps? | Y | P | N | Goiter? | Y | P | N |
| Swollen glands? | Y | P | N | Stiff/painful neck? | Y | P | N |

## Cardiovascular

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Chest pain? | Y | P | N | Palpitations/flutters? | Y | P | N |
| Murmur? | Y | P | N | Swelling of ankles? | Y | P | N |
| Blood clots? | Y | P | N | Congenital defect? | Y | P | N |
| Fainting? | Y | P | N | Rheumatic fever? | Y | P | N |

## Respiratory

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Cough? | Y | P | N | Sputum? | Y | P | N |
| Spitting up blood? | Y | P | N | Wheezing? | Y | P | N |
| Asthma? | Y | P | N | Shortness of breath? | Y | P | N |
| Pneumonia? | Y | P | N | Bronchitis? | Y | P | N |
| Pleurisy? | Y | P | N | Tuberculosis? | Y | P | N |
| Pain on breathing? | Y | P | N | Difficulty breathing? | Y | P | N |
| Lightheaded with exertion? | Y | P | N | Shallow breathing? | Y | P | N |

## Gastrointestinal

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Difficulty swallowing? | Y | P | N | Heartburn? | Y | P | N |
| Change in thirst? | Y | P | N | Change in appetite? | Y | P | N |
| Ulcer? | Y | P | N | Nausea? | Y | P | N |
| Vomiting? | Y | P | N | Vomiting blood? | Y | P | N |
| Belching or gas? | Y | P | N | Pain or cramps? | Y | P | N |
| Bowel movements: how often_____<br>Is this a change? Y N | | | | Diarrhea? | Y | P | N |
| Constipation? | Y | P | N | Blood in stool? | Y | P | N |
| Black stool? | Y | P | N | Hemmorhoids? | Y | P | N |

## Urinary

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Pain on urination? | Y | P | N | Increased frequency? | Y | P | N |
| Frequency at night? | Y | P | N | Inability to hold urine? | Y | P | N |
| Frequent urinary tract infections? | Y | P | N | Kidney Stones? | Y | P | N |
| Kidney disease? | Y | P | N | Abnormal color or smell of urine? | Y | P | N |

## Male Reproductive

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Hernias? | Y | P | N | Testicular masses? | Y | P | N |
| Testicular pain? | Y | P | N | Sexually active? | Y | P | N |

## Female Reproductive/Breasts

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Age of first menses? | | | | Age of last menses? | | | |
| Is your cycle regular? | Y | P | N | Duration of cycle (#days)? | | | |
| Duration between cycles (# days)? | | | | Bleeding between cycles? | Y | P | N |
| Pain/cramping during menses? | Y | P | N | Heavy or excessive flow? | Y | P | N |
| Clotting? | Y | P | N | Ovarian cysts? | Y | P | N |
| Fibroids? | Y | P | N | Endometriosis? | Y | P | N |
| Abnormal Pap? | Y | P | N | Cervical dysplasia? | Y | P | N |
| Sexually active? | Y | P | N | Birth Control Method? | | | |
| Vaginal discharge? | Y | P | N | Vaginal itching? | Y | P | N |
| Breast Lumps? | Y | P | N | Interstitial cystitis? | Y | P | N |
| Breast pain or tenderness? | Y | P | N | Nipple discharge? | Y | P | N |

## Musculoskeletal

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Joint pain or stiffiness? | Y | P | N | Broken bones? | Y | P | N |
| Muscle cramps? | Y | P | N | Muscle weakness? | Y | P | N |

## Blood/Peripheral Vascular

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Easy bleeding? | Y | P | N | Easy bruising? | Y | P | N |
| Anemia? | Y | P | N | Swelling? | Y | P | N |

Is there any other information about your child's health that you would like to add?

Signature:_____ Date:_____

*Thank you for taking time to help me better understand your child's whole health. I look forward to working with you and your child. If you have any questions please ask!*

*Dr. Holcomb Johnston*