Sweetgrass
NATURAL MEDICINE

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PEDIATRIC INTAKE FORM (Birth to 5 years)

Patient's Name:_____ Today's Date:_____

Date of Birth:_____ Age:____ Gender: M / F

Parent/Guardian's Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Parent's E-mail:_____

Phone: (home)_____(cell)_____(work)_____

Is it ok to call and leave a message at home? Y N On your cell? Y N At Work? Y N

Doctor's office/hospital/clinic where your child's health records are kept_____

_____

Has any family member been a patient at our clinic? Y N If yes, who?_____

How did you hear about Sweetgrass Natural Medicine?_____

Reason for today's visit or chief complaint?_____

MEDICATIONS

Now	Past		Now	Past	
____	____	Aspirin	____	____	Decongestants
____	____	Tylenol	____	____	Anti-histamines
____	____	Antibiotics	____	____	steroids/cortisone
____	____	Ibuprofen	____	____	Other:_____

Allergies to medicines:_____

MEDICAL HISTORY

_____Chicken pox	_____Scarlet fever	_____Tonsillitis, number of times:_____
_____Measles	_____Pneumonia	_____Ear infections, number of times:_____
_____Mumps	_____Frequent colds	_____Strep throat, number of times:_____
_____Rubella	_____Rheumatic fever	_____Other:_____

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

Electroencephalogram (EEG):_____

Hearing tests:_____

Speech/Language tests:_____

Psychological evaluation:_____

Injuries/surgeries/hospitalizations (please list)_____

_____

IMMUNIZATIONS

___MMR	___DPT	___Chicken pox	Others:_____
___Measles	___Diptheria	___Small pox	
___Mumps	___Tetanus	___H. influenza	Adverse reactions? Y N
___Rubella	___Polio	___The flu	Please describe:_____

_____

FAMILY HISTORY

_____ Heart disease	_____ Diabetes	_____ Birth defects
_____ Hypertension	_____ Arthritis	_____ Tuberculosis
_____ Cancer	_____ Allergies	_____ Mental illness

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications?

Mother's age at child's birth? _____

Mother's health during pregnancy?

_____ Bleeding	_____ Physical or emotional trauma	
_____ Nausea	_____ Cigarettes, alcohol, drug consumption	
_____ Illnesses	_____ Medications	
_____ Hypertension	_____ Thyroid problems	_____ Diabetes

BIRTH HISTORY

Term: Full _____ Premature _____ Late _____ Weight at birth_____

Length of labor _____ Complications? _____

Did your child have any of the following problems shortly after birth?

_____ Birth defects	_____ Birth injuries	_____ Blue baby
_____ Cerebral palsy	_____ Seizures	_____ Jaundice
_____ Colic	_____ Fever	_____ Rashes

Other: _____

Child's sleep patterns (1st year) _____

Food intolerances (if any) _____

Feeding: Breast fed? Y N How long? _____ Formula? Y N milk / soy _____

Age began solids _____ Which foods? _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS (mark Y if current, P for past symptoms, leave blank if never)

_____ Hives
_____ Eczema
_____ Bleeding gums
_____ Nose bleeds
_____ Acne
_____ High fevers
_____ Chronic rash
_____ Hearing loss
_____ Diarrhea
_____ Sore throats
_____ Headaches
_____ Frequent colds
_____ Wheezing
_____ Cough

_____ Burning of urine
_____ Frequent urination
_____ Heart murmur
_____ Vomiting spells
_____ Anemia
_____ Stomach aches
_____ Jaundice
_____ Easy bruising
_____ Flat feet
_____ Constipation
_____ Gas
_____ Bleeding tendency
_____ Joint pains
_____ Dizzy spells

_____ Bloody urine
_____ Cries easily
_____ Nervous
_____ Sleep problems
_____ Night sweats
_____ Sensitive to light
_____ Body/breath odor
_____ Motion/car sickness
_____ No appetite
_____ Nightmares
_____ Canker sores
_____ Unusual fears
_____ Excessive fatigue
_____ Hair loss

DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Other Concerns:

Thank you. We look forward to helping your child in any way we can.