Dr. Kevin Jackson N.D.

PEDIATRIC INTAKE FORM

Date_____________________

Child's Name____________________________ Age________
Sex________Birthdate_______________
Address____
Phone__________________________

Parent/Guardian's Name____
Address (if different from above)____
Phone (Home)______________________________Phone (Work)_______________________________

How were you referred to this office?____
Name of Family Medical Doctor____

CHIEF COMPLAINT
What is the chief concern about your child's health?
____
____
____
How long has this condition been present?____
Has this condition been diagnosed by any other practitioner?
____
Have any specialists been consulted?____
Until now how has this condition been treated?
____
____
Are there any other concerns about your child's health? (For how long has each existed?)
1.____
2.____
3.____
4.____
5.____
How long has it been since your child was completely well?
____

PAST MEDICAL HISTORY
Please list the child's past medical history (Surgeries, Hospitalizations, Transfusions etc.)
1.____
2.____
3.____
4.____
5.____
Please list any accidents or trauma the child has suffered including when, severity and treatment
1.____
2.____
3.____
Please list any exposures the child has experienced (poisons, chemicals, sunburns etc.)
1.____
2.____
3.____
Is the child exposed to tobacco smoke? If yes, how often?
____

VACCINATIONS

Check any of the following immunizations your child has had.

Measles, Mumps, Rubella ❐ Diphtheria, Pertussis, Tetanus ❐ Polio ❐ Influenza ❐

Smallpox ❐ Hepatitis ❐

Other____

If your child has ever had a negative reaction to a vaccination, what was the reaction, when was it given and what type of vaccine was it?

____

____

PREVIOUS MEDICAL HISTORY (Please check those that are applicable)

Measles ❐	Sinusitis ❐	Hives ❐
Mumps ❐	Eczema ❐	Asthma ❐
Scarlet fever ❐	Pleurisy ❐	Eye Infections ❐
Whooping cough ❐	Herpes ❐	Diphtheria ❐
Croup ❐	Hay Fever ❐	Candida ❐
Pneumonia ❐	Chicken Pox ❐	Swollen Glands ❐
Tuberculosis ❐	Allergies ❐	Frequent Colds ❐
Ear Infections ❐	Influenza ❐	Tonsillitis ❐
Rheumatic Fever ❐		

Other____

RECURRENT SYMPTOMS (Please check those that are applicable)

Nosebleeds ❐	Painful Urination ❐	Sore Throats ❐
Hyperactivity ❐	Frequent Urination ❐	Easy Bruising ❐
Strong Fears ❐	Bed Wetting ❐	Diarrhea ❐
Hearing Problems ❐	Blood In Urine ❐	Constipation ❐
Dizziness ❐	Tendency To Bleed ❐	Stomach Aches ❐
Hair Loss ❐	Body/Breath Odor ❐	Wheezing ❐
Night Sweats ❐	Change In Appetite ❐	Cough ❐
Sleep Problems ❐	Frequent Vomiting ❐	Nervousness ❐
Cries easily ❐	Other____	

FAMILY HISTORY (Please indicate the age of all of the following relatives that are living and the age at which any have become deceased, L= living, D= deceased)

Brother L________ D________	Sister L________ D________
Brother L________ D________	Sister L________ D________
Father L________ D________	Mother L________ D________
Paternal Grandmother L________ D________	Maternal Grandmother L________ D________
Paternal Grandfather L________ D________	Maternal Grandfather L________ D________

Indicate the number of the above relatives that have or have had the following diseases:

Diabetes_____
Kidney Disease_____
Cancer_____

Mental Illness_____
Stomach Disorders_____
Arthritis_____

Alzheimer's Disease_____
High Blood Pressure_____
Goiter_____

Birth Defects_____
Heart Disease_____
Rheumatism_____

Allergies_____
Tuberculosis_____

PRENATAL HISTORY - Mother's Health During Pregnancy (Please check applicable box)

Physical/Emotional Trauma ❒ **Thyroid Problems ❒** **Nausea ❒**
High Blood Pressure ❒ **Medications ❒** **Illnesses ❒**
Cigarette/Alcohol/Drug Use ❒ **Bleeding ❒** **Diabetes**
Other____
Mother's age at childbirth_________________________

BIRTH HISTORY - Term (Please check applicable box)

Full ❒ **Premature ❒** **Late ❒**
Child's weight at birth________ Length of labour________ C-section or Vaginal birth? ______________
Complications____

Were any of the following experienced by your child at or soon after birth?
diarrhea ❒
birth defects ❒
rashes ❒

colic ❒
birth injuries ❒
jaundice ❒

vomiting ❒
seizures ❒
infections ❒

Other____

MEDICATIONS & SUPPLEMENTS

Please list all medications that your child is currently taking - include dosage, frequency and name
1.____
2.____
3.____
4.____

Please list any medications to which your child has had an adverse reaction
1.____
2.____
3.____

How many courses of antibiotics has your child had in his/her lifetime ? ___________________________

Please list any over the counter medications that your child has been given
1.____
2.____
3.____

Please list all supplements that your child is taking - include dosage, frequency and name
1.____
2.____
3.____
4.____
5.____

GENERAL INFORMATION
Please describe your child's sleep pattern____
How many hours of sleep does your child average per 24 hour period ? __________________________
Does your child have any food sensitivities/intolerances/allergies that you are aware of ?- _____________
If so what are they ?____
____
What foods does your child crave ?____
____
Was your child breast fed ?__________ **If so, for what period of time ?** __________________________
For what period of time was your child fed formula ?________________**cow's milk ?** ________________
soy milk ?_______________ **other ?**________________
At what age did your child begin eating solid food ?__________________
At what age did your child begin sitting ?___________ **crawling ?**___________ **walking ?** ___________
speaking first words ?_____________ **gain his/her first full set of teeth ?**______________