

INTAKE - YOUTH
NATUROPATHIC MEDICINE

Date: _____

Patient's Name: _____ Date of Birth: _____

Parent/Guardian's Name: _____

Current Providers:

Pediatrician: _____

Name

Phone

Counselor/Therapist: _____

Name

Phone

Psychiatrist: _____

Name

Phone

Additional Providers (name and phone):

What are your major concerns about your child's health?

1. _____
2. _____
3. _____
4. _____

What are your goals or expectations for today's visit?

Medical History:

Pneumonia _____

Tonsilitis _____

Ear infections _____

Strep throat _____

Asthma _____

Allergies _____

Colic _____

Croup _____

Frequent Colds _____

Other Significant History: _____

Date of last physical exam: _____ Date of last dental exam, if applicable: _____

Has your child had any of the following? Please include when, where and results:

Electroencephalogram (EEG): _____

Psychological Evaluation: _____

Hearing Test: _____

Injuries/Surgeries/Hospitalizations: _____

Family History:

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Eczema
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Cancer	<input type="checkbox"/> Allergies	
<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Osteoporosis	

Other significant family history: _____

Allergies:

Is your child allergic or hypersensitive to:

Medications: _____

Foods: _____

Environmental/Seasonal: _____

Health and Development:

How would you describe your child's general health?

- Poor Fair Good Excellent

Describe your child's sleep pattern: _____

Current Medications or Supplements (with dosages): _____

Environment:

Is your child in:

____ School (grade ____) ____ Daycare ____ Home Care Other: _____

What school does your child attend? _____

What are your child's favorite activities? _____

Does your child exercise regularly? Y / N How much and how often? _____

How much screen time does your child engage in? _____ hours a day/week

Does anybody in the house smoke? Y / N

Are there any animals in the house? Y / N Type: _____

How would you describe the emotional climate of the child's home? _____

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

**Thank you for choosing Intuition Wellness Center to assist your child
and family to live in health and joy!**