intuition wellness center
LEARN. GROW. THRIVE.

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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:

_____ *Heart Disease*	_____ *Diabetes*	_____ *Eczema*
_____ *Hypertension*	_____ *Arthritis*	_____ *Asthma*
_____ *Cancer*	_____ *Allergies*	
_____ *Mental Illness*	_____ *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!