Flying Crane Wellness Studio
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PEDIATRIC INTAKE FORM Today's Date: _____

Name: _____ Nickname: _____

Date of Birth: _____

Male Female

Usual Address: _____

Mother's Name: _____
Mother's Mailing Address:(if different) _____
Home phone: _____ Cell phone: _____
Email: _____

Father's Name: _____
Father's Mailing Address (if different): _____
Home phone:_____ Cell Phone: _____
Email: _____

Do both parents agree to treatment for this child? Y N

Where is the best place to leave messages? _____

Who does this child usually live with? (Include all family members):
_____
_____
Who is your pediatrician?
_____

Address_____Phone_____
When, where and from whom did your child last receive medical/health care?
_____
_____

Is your child currently under the care of any medical specialists? _____

If so, please list:
_____
_____

Is your child currently seeing any other health care provider? EX: another naturopathic physician, chiropractor, acupuncturist, massage therapist, counselor, etc. If so, please list:

_____
_____
_____

HEALTH HISTORY QUESTIONNAIRE

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

_____
_____
_____
_____

In general, how is your child's health? _____

Does your child have a contagious disease at this time? Y N If so, what? _____

Context of Care

What does your child LOVE to do? _____

What does your child spend the most time doing? _____

How much time does your child spend outside every day? _____

How would you describe your child's personality? _____

How does your child interact with others? _____

What do you believe are potential obstacles to your child's optimal health?

_____

How committed are you to helping your child meet their health goals? (Rate from zero to 100% commitment)

0% 10 20 30 40 50 60 70 80 90 100%

Will ALL other family members support your child to meet their health goals? Y N If no, please explain:

_____
_____

Habits

Sleeps well? Y N How many hours/ night? _____

Awakens rested? Y N What time? _____

Watches television? Y N How many hours? _____

Plays on electronic devices? Y N How many hours? _____

Reads? Y N How many hours? _____

Hobbies? _____ Sports? _____

Prenatal

In general, how was this child's mother's health during pregnancy? Did she have any major illnesses, accidents, traumas or stress? If yes, please describe:

_____
_____
_____

Was this child delivered full-term (≥ 37wks)? Y N

Vaginal or C-Section birth?

Birth Weight: _____

Any problems or complications during birth? Y N If yes, please explain:_____
_____

Has this child had any developmental problems? Y N If yes, please explain:

_____
_____

Previous Illness

Measles Y N Mumps Y N

Strep Throat Y N Ear Infections Y N

Whooping cough Y N Bronchitis Y N

Rheumatic Fever Y N Chicken Pox Y N

Tonsillitis Y N Other Y N

Other: _____

Has your child had any of the following tests? If so, when & where:
Electroencephalogram (EEG):_____

Psychological evaluation:_____
_____

Hearing tests: _____

Speech/Language evaluation:_____

Hospitalizations/Surgeries/Injuries

Has this child experienced any major accidents, illness, trauma or stress? If so, please explain:
_____
_____
_____

Has this child ever been to the hospital? If so, why?
_____
_____

Immunizations

Has this child received the standard vaccinations according to the current recommendations? Y N

If not, have they received any of the following vaccines?

Polio Y N	Hepatitis Y N
Tetanus Y N	DTP Y N
Measles/Mumps/Rubella Y N	Chicken Pox Y N
Hepatitis A Y N	Hepatitis B Y N
Pertussis Y N	Diphtheria Y N
Influenza Y N	Meningitis Y N

Others? (i.e. for travel) _____

Has this child ever had an adverse reaction to any vaccine? Y N

Please describe:
_____
_____

Allergies

Is this child hypersensitive or allergic to any of the following? Please list:

Drugs? _____

Foods? _____
_____

Environmental Allergens?_____

Breast fed? Y N How long? _____ Formula? Y N What type? _____
At what age was solid food introduced? _____

Typical Food Intake

Daily Diet

Breakfast:

Lunch:

Dinner:

Snacks:

Drinks:

Regularly eats refined sugar? Y N

Please list any prescription medications, over the counter medications, vitamins or other supplements your child is taking:
_____
_____
_____

** Please bring all of your child's medications and supplements to their first appointment

REVIEW OF SYSTEMS N = a condition now, P = a condition in the past

Mental/Emotional

Mood Swings	N P	Irritability	N P
Attention deficit	N P	Hyperactivity	N P
Dyslexia	N P	Unusual fears	N P

Introvert/extrovert	N P	Cries easily	N P
Anxiety	N P	Nervousness	N P
Sleep problems	N P	Nightmares	N P
Problems at school	N P		

Endocrine

Excessive thirst	N P	Excessive hunger	N P
Low blood sugar	N P	High blood sugar	N P
Fatigue	N P	Heat/cold intolerance	N P

Head

Head or neck Injury	N P	High Fevers	N P
Headaches	N P	Dizzy spells	N P
Motion/car sickness	N P		

Eyes

Glasses	N P	Lazy Eye	N P
Eye pain/strain	N P	Tearing or dry eyes	N P

Date of last eye exam: _____

Ears

Frequent Earaches	N P	Excessive ear wax	N P
Ringing in the ears	N P	Impaired Hearing	N P

Nose and Sinuses

Frequent colds	N P		
Sinus problems	N P	Chronic congestion or stuffy nose	N P
Bloody noses	N P	Loss of smell	N P

Mouth and Throat

Frequent sore throat	N P	Canker Sores	N P
Bad breathe	N P		

Digestion

Stomach aches	N P	Vomiting	N P
Reflux	N P		

Gastrointestinal

Daily bowel movements	N P		
Belching/passing gas	N P		
Constipation	N P	Diarrhea	N P

Urinary

Frequent urination	N P	Bedwetting	N P
Bladder infection	N P		

Respiratory

Chronic or frequent cough	N P		
Asthma	N P	Hay Fever	N P
Snoring	N P	Wheezing	N P

Cardiovascular/ circulatory

Heart disease	N P		
Murmers	N P		
Anemia	N P	Easy bruising/ bleeding	N P

Musculoskeletal

Poor coordination	N P	Joint pain/stiffness	N P
Muscle spasms/ cramps	N P	Muscle stiffness	N P
Broken bones	N P		

Skin

Eczema	N P	Psoriasis	N P
Rashes	N P	Hives	N P
Acne	N P	Boils	N P

Are there any other concerns you would like me to be aware of:

_____
_____
_____
_____

Cancellation Policy

Scheduled appointments are reserved especially for you. I ask for 48 hour notice for cancellations or rescheduling. Patients with same day cancellations or no-shows will be charged half of their original appointment fee. This must be paid prior to rescheduling. Thank you for your cooperation.

Please Print:

I,_____, parent or legal guardian of _____, (patient's full name) agree to pay my full account at the time of each visit or treatment, including fees for appointments, services, cost of supplements and remedies, cost of laboratory tests, administrative fees, missed appointment fees as well as other applicable fees.

Date: _____

Signature of parent or legal guardian:_____