Western North Carolina
NATUROPATHIC MEDICINE
Dr. Janet Opila-Lehman, ND

NEW PEDIATRIC INTAKE FORM

Thank you for taking the time to fill out this form as completely as possible before your child's visit.

Client's name: ____ Date: ____________________

Address: ____

City: ____ State: ________________ Zip: ________________

Telephone (home/cell): ______________________ (parent's work): ____________________________________

Child's Age: ________________ Date of birth: ______________________ Gender: F M

Mom's Name: ____

Daytime telephone: _________________________ Email: ____

Dad's Name: ____

Daytime telephone: _________________________ Email: ____

Parents are: Married _______ Divorced _______ Separated _______ Single _______

With whom does your child live? ____

Parents, how would you prefer to be contacted? home work email

May we leave a message? home work email

Child's school/daycare: ____

Emergency contact: ______________________________________ Relationship: __________________________

School/Daycare Phone: _______________________________________

Name of current Pediatric Provider: ____

Ok to contact? ___Yes ___ No Email: __________________________ Phone: __________________________

Address? ____

When was your child's last visit to the doctor's office? ______________ What was the reason? __________________

____

Is your child under the care of a medical specialist or health care practitioners? Who? ________________________

Ok to contact? ___Yes ___ No Email: ________________________________ Phone: ______________________

Address: ____

Has he/she seen a naturopathic doctor before? ________ Who? ____________________ When? ____________________

Parents, how did you hear about Dr. Janet? ____

Tell me about your child.

Strengths:____

What are your child's most important health concerns?

1)____

2)____

3)____

4)____

When did you first notice your child's problems? ______________________________

What did you notice first?______________________________

Was the onset? _____ sudden _____ gradual

Was there any event or action that you think might have contributed to your child's symptoms?

____

Is your child adopted? ___Yes ___ No If yes, what age and circumstances?

____

What are your goals pertaining to your child's health, both short- and long-term?

____

Parents

Mom's Age now?_____________
Highest grade completed: ______________________Occupation: ______________________
Any health concerns?____
Dad's Age now?____________
Highest grade completed: ______________________Occupation: ______________________
Any health concerns?____

Siblings

Name:______________________________ Male Female Age:

Any health concerns? ______________________________Live at home: ___Yes ___ No

Name:______________________________ Male Female Age:

Any health concerns? ______________________________Live at home: ___Yes ___ No

Name:______________________________ Male Female Age:

Any health concerns? ______________________________Live at home: ___Yes ___ No

PRENATAL/BIRTH/FEEDING HISTORY

Mom's age at child's birth: ____________ Dad's age at child's birth: ____________

Did any of the following occur during your pregnancy? If yes, describe.

Trauma/injury? _________ Bleeding during pregnancy? ______________________Stress? ________________________

Alcohol consumption? ____________________Drug use? ___________________Smoking? _______________________

Medications? ____

Nausea? __________________High blood pressure? ____________________Illness? _____________________________

X-rays?_______________ Diabetes?____________Toxemia?_____________Thyroid problems? ____________________

Other? ____

TERM: Full _____ Premature _____ Late _____ Birth weight: ___________________________

Length of labor: ________________ Was birth… Easy _____Moderate _____ Difficult _____

Vaginal delivery? ___Yes ___ No C-section? ___Yes ___ No

Any complications? ____

Place of birth: Hospital _____ Home _____ Clinic _____ Other ______

Did Mom or Dad have any significant adjusting after the birth? Describe: _______________________________________

FEEDING:

Breast fed? ___Yes ___ No How long? ______________________________ Any difficulties? ___________________

Formula? ______________________How long? ________________ _________What kind? ________________________

Age solid foods introduced: __________________________

Favorite foods: ____

Food intolerances: ____

DEVELOPMENTAL HISTORY: Please describe each stage as - early, average or late.

1. Motor development (sitting, crawling, walking): ____

2. Speech and Language: ____

    a) First words: ______________________Age: _____________

    b) First phrases or sentences: ____Age: ______________

3. Self-help skills (dressing, brushing teeth, bathing, self-feeding): ____

4. Age of being Bowel trained: _________________________Age of being Bladder trained: _________________________

5. Handedness: _____Right _____ Left

6. Writing skills: ___ Good ___ Average ___ Poor

7. Athletic abilities (climbing, gymnastics, sports): ___ Good ___ Average ___ Poor

8. Does your child have an excess of accidents compared to other kids? ___Yes ___ No

DAILY LIFE: (currently) Does your child….

1. Understand directions and situations as expected? ____________________________
2. Any trouble remembering things? ____
3. Any difficulties with routines (bedtime, school schedule, etc)? __________________
4. Frequently lose things or have trouble being organized? _______________________
5. How many hours/night? _____________Falls asleep? ___Easy ___Average ___Hard
6. How difficult to wake? ___Easy ___Average ___Hard

SCHOOL: Current grade in school: _________________

1. Overall level of intelligence compared to others the same age? ___________________
2. School schedule? ____
3. Any know learning disabilities? ____
4. In any special programs (Speech, Reading, Occupational Therapy, etc):

   ____
5. Does your child enjoy school? ____
6. Strengths? ____
7. Weaknesses? ____
8. Any issues at school? ____
9. Any extracurricular activities? List: _______________________________________
10. Does your child make friends easily? ______________________________________

MEDICAL HISTORY

Allergies

Is your child allergic or hypersensitive to any medications, supplements or environmental or chemical agents?

Describe: ____

____

Hospitalizations/surgeries/special tests

Please list any surgical procedures, hospitalizations, X-Rays, CAT scans, MRIs, EKGs, EEGs, hearing tests, vision tests, speech/language tests, or psychological evaluations your child has had done in the past couple years.

Test	*Date*	*Result*

Any blood/urine stool tests done? ___Yes ___ No (Please bring in copies of results)

MEDICATIONS/SUPPLEMENTS

Current Medications:

Medication	Dose	Frequency	Start Date (month/year)	Reason for Use

Nutritional Supplements (Vitamins, Minerals, Herbs, Homeopathy, Other)

Supplement/Brand	Dose	Frequency	Start Date (Month/year)	Reason for Use

Have medications or supplements ever caused side effects or problems? ___Yes ___ No
Describe: ____

Any prolonged or regular use of Tylenol? ___Yes ___ No

Frequent antibiotics >3 times/year ___Yes ___No Long term antibiotics? ___ Yes ___ No

Use of steroids (prednisone, nasal allergy inhalers) in the past? ___Yes ___ No

Immunizations

MMR _____	DPT _____	Chicken pox _____	Small pox _____
Measles _____	Diphtheria _____	H. influenza _____	Hepatitis B _____
Mumps _____	Rubella _____	Tetanus _____	Polio _____
Pertussis_____	Other ____________________		

Adverse reactions? ___Yes ___No Describe:____

Vision: Last tested? ______________________ **Hearing**: Last tested? ______________________

SIGNS & SYMPTOMS: (Please check any that apply)

NOW	PAST		NOW	PAST		NOW	PAST	
_____	_____	Aggressiveness	_____	_____	Anal Itching	_____	_____	Anxieties
_____	_____	Bad Breath	_____	_____	Blinking	_____	_____	Breath Holding
_____	_____	Dark Circles under Eyes	_____	_____	Fidgeting	_____	_____	Food Cravings
_____	_____	Grinding Teeth	_____	_____	Head Banging	_____	_____	Hyperactive
_____	_____	Impulsiveness	_____	_____	Itching	_____	_____	Lack of Focus
_____	_____	Low Self-Esteem	_____	_____	Mood Swings	_____	_____	Nail Biting
_____	_____	OCD	_____	_____	Poor Coordination	_____	_____	Rocking
_____	_____	Reflux	_____	_____	Self-Mutilation	_____	_____	Sensitive to Crowds
_____	_____	Sensitive to Noises/Lights	_____	_____	Skin-Picking	_____	_____	Social Problems
_____	_____	Stiffness	_____	_____	Strong Body Odor	_____	_____	Tantrums
_____	_____	Tics	_____	_____	Toe Walker	_____	_____	White Spots on Nail

CHILD's HEALTH HISTORY (please check any that apply)

NOW	PAST		NOW	PAST	
_____	_____	Acne	_____	_____	Hearing loss
_____	_____	Allergies	_____	_____	Heart murmur
_____	_____	Anemia	_____	_____	Heat intolerant
_____	_____	Asthma	_____	_____	High fever
_____	_____	Bed wetting	_____	_____	Hives
_____	_____	Birth defects	_____	_____	Insomnia
_____	_____	Bleeding gums	_____	_____	Jaundice
_____	_____	Blood in stools	_____	_____	Joint pains
_____	_____	Calf Cramps	_____	_____	Learning disorder
_____	_____	Chicken pox	_____	_____	Measles
_____	_____	Chronic rashes	_____	_____	Mononucleosis

_____ _____ Colic
_____ _____ Cold Hands/Feet
_____ _____ Congestion
_____ _____ Constipation
_____ _____ Cough/Wheeze
_____ _____ Cradle cap
_____ _____ Croup
_____ _____ Depression
_____ _____ Diarrhea
_____ _____ Dizzy spells
_____ _____ Dry Skin
_____ _____ Earaches
_____ _____ Ear infections
_____ _____ Easy bruising
_____ _____ Eczema
_____ _____ Epilepsy/seizures
_____ _____ Fatigue
_____ _____ Flat feet
_____ _____ Frequent colds
_____ _____ Frequent fever
_____ _____ Frequent headaches
_____ _____ Frequent urination
_____ _____ Hair loss
_____ _____ Headaches
_____ _____ Mumps
_____ _____ Nightmares
_____ _____ Nosebleeds
_____ _____ Numbness in arms/legs
_____ _____ Oily skin
_____ _____ Pneumonia
_____ _____ Psoriasis
_____ _____ Rashes
_____ _____ Rheumatic fever
_____ _____ Ringing in ears
_____ _____ Rough skin
_____ _____ Rubella
_____ _____ Scarlet fever
_____ _____ Seizures
_____ _____ Sore throats
_____ _____ Stomachaches
_____ _____ Strep throat
_____ _____ Stuffy nose
_____ _____ Thrush
_____ _____ Tonsillitis
_____ _____ Tremors
_____ _____ Urinary tract infections
_____ _____ Vomiting spells
_____ _____ Wheezing
_____ _____ Whooping cough
Other: ____________________________

FAMILY HISTORY (please circle any that apply)

Alcoholism Allergies Anemia Arthritis Asthma
Birth defects Cancer Diabetes Eczema Epilepsy
Heart disease Hearing loss High blood pressure Hypoglycemia Mental illness
Obesity Stroke Thyroid disorder Tuberculosis
Other: ____

NUTRITION: **Height: ____________________ Weight: ______________________**

Have your child tried any dietary modifications? ___Yes ___No Results? ______________________________

Check all that apply:

_____ Low fat _____ High protein _____ Diabetic _____ Gluten free _____ Dairy free
_____ Vegetarian _____ Vegan _____ Low carb _____ Low salt _____________Other

Any food allergies? Which? ____

Describe your child's reactions? ____

Do your child avoid any specific foods? ___Yes ___No Which? ______________________________

Do your child crave any specific foods? ___Yes ___No Which? ______________________________

What would you like to change about the way your child eats?
____

Please describe your child's typical daily diet:

Breakfast: ____________________

Lunch: ____________________

Dinner: ____________________

Snacks: ____________________

Drinks: ____________________

Overall Appetite? ____________________

Bowel movements/day? ____________________ Form? ____________________Color?____________________
Diarrhea? __________ Constipation? __________ Do your child digest food well? ___ Yes ___ No
Do your child feel bloated after eating? ___Yes ___ No
Any recent foreign travel? ___ Yes ___ No Where? ____________________
Any wilderness camping? ___ Yes ___No Where? ____________________

EXERCISE
Hobbies/interests:____________________

Exercise Activity	*Frequency/Week*	*Duration in minutes*
Bike riding		
Swimming		
Dance		
Sports		
Other		

ENERGY
How would you rate your child's focus/attention on a scale of 1-10? (0=least 10=most): ____________________
How would you rate your child's activity level on a scale of 1-10? (0=none 10=constant):____________________
How would you rate your child's energy level during the day? (0=no energy 10=overenergized): ____________
List any problems that you think affect your child's energy: ____________________

SLEEP
Sleep: Average # hours/night? ____________________How long to fall asleep?____________________
Waking during the night? ___Yes ___No How often? ____________________
Waking rested? ____________________
Do you have to wake your child in the morning? ___Yes ___No
Doe your child snore? _____Yes ____No Do your child use any sleeping aids? ____Yes ____No

SPIRITUALITY

Please list your family's spiritual orientation or religion (optional): ____________________
How active are there beliefs in your life? Very active Somewhat Not very active

SAFETY

Is there a working fire alarm on each floor of your house? Yes No

Are there any firearms in your home? Yes No If so, are they securely locked? Yes No

Is your child buckled into a securely fastened car seat or seat belt while riding in a car? Yes No

Does your child wear a helmet while bike riding, skateboarding, skiing, etc? Yes No

Are there any smokers in the home or childcare setting? Yes No

ENVIRONMENTAL ASSESSMENT

Do any of these items negatively affect your child?

_____ Monosodium glutamate (MSG) _____Aspartame (Nutrasweet) _____Caffeine _____Chocolate

_____ Bananas _____Garlic _____Onion _____Cheese _____Citrus foods _____ Preservatives

_____ Alcohol _____Red wine _____Sulfite foods (wine, dried fruit, shellfish)

____ Other

Do any of these items negatively affect your child?

_____ Cigarette smoke _____Perfumes/colognes _____Auto exhaust fumes _________________Other

Does your child's school or home environment include exposure to?

_____ Chemicals _____Electromagnetic radiation _____ Mold

Is there any old / peeling paint inside or outside the home? Yes No

Has your child ever had the following? _____Yellow color (jaundiced) _____Gilbert's syndrome _____Liver disorder

Has your child ever been knowingly exposed to?

____ Herbicides _____Insecticides (frequent exterminators) _____Pesticides _____Organic solvents

____ Heavy metals ____Other

Do you have any farm animals? _____ Yes _____No

Do you have any pets? _____ Yes _____No Name(s): ____

Please include any other information about your child that you would like to share:

____

____

____

____

Thanks for taking the time to share this valuable information about your child.

Dr. Janet Opila-Lehman, ND