Providence Wholistic Healthcare
Integrative Natural Family Medicine & Acupuncture
Sheila M. Frodermann, MS, ND, DHANP, CCH • Carol L. Seng, MAOM, DA, LAc
144 Waterman Street, Suite #3 Providence, RI 02906
www.providencewholistic.com
(401) 455-0546

Pediatric Intake Form

Welcome! It is our goal to provide your child with the best possible complementary natural health care. In order to serve you optimally, please answer the following questions about your child. Thank you!

Child's Name _____ Date _____
Address _____ Zip _____
Birthdate _____Age _____ Female Male Home Phone_____
Names: Parent 1 _____ Mother Father (Cell #)_____
Parent 2 _____ Mother Father (Cell#)_____
Parent Email: _____ Other Guardian _____
How did hear about this clinic_____ Referred By _____
Person to be notified in case of an emergency _____
Relationship_____ Phone _____
Address_____

List (1) all health problem(s) that are the reason for this appointment, (2) other health concerns:
1._____
2._____
3._____
4._____
5. _____

Does your child have a contagious illness at this time? Y N If yes, what? _____
Is your child allergic or hypersensitive to any of the following (Y or N and list known specifics):
Drugs/Medication Y N
_____
Environmental Y N _____ Worst Season(s) _____
Foods Y N
_____

Medications:	Now	Past	Frequency	**Supplements:**	Now	Past	Dose
Aspirin	_____	_____	_____	Vitamins	_____	_____	_____
Tylenol	_____	_____	_____	Minerals	_____	_____	_____
Antibiotics	_____	_____	_____	Fluoride	_____	_____	_____
Decongestants	_____	_____	_____	Herbs	_____	_____	_____
Other _____				Other_____			

Childhood Illnesses Y (yes) **N** (no)

_____ Chicken Pox	_____ Scarlet Fever	_____ Mononucleosis
_____ Measles	_____ Rheumatic Fever	_____ Ear Infections
_____ Mumps	_____ Strep Throat	_____ Tonsillitis
_____ Rubella	_____ Pneumonia	_____ Other _____

Childhood Immunizations: (circle types; notes any adverse reactions)

HIB	DPT	Measles/Mumps/Rubella	Hepatitis B	HPV
Polio	Varicella	Tuberculosis Test	Influenza	Other_____

Hospitalizations/Surgeries/Accidents/Serious Injuries: (describe each incident and give dates):

_____

_____

_____

Childhood Testing: Has your child had any of the following tests? When? Diagnosis?

EEG (electroencephalogram)_____

Psychological evaluation _____

Hearing tests_____

Speech/Language tests_____

Neurological evaluation_____

Family History: Identify family members who have, or have had, any of the following: M, F, PGM, etc

_____ Alcoholism	_____ Epilepsy	Other_____
_____ Allergies	_____ Heart Disease	Other_____
_____ Anemia	_____ Hearing Loss	
_____ Arthritis	_____ High Blood Pressure	Does your child have any of these?
_____ Asthma	_____ Hypoglycemia	_____
_____ Birth Defects	_____ Mental Illness	_____
_____ Cancer	_____ Obesity	
_____ Diabetes	_____ Stroke	
_____ Eczema/Dermatitis	_____ Thyroid Disorder	

Infant's/child's/Adolescent's Health History

Now	**Past**	**Never**		**Now**	**Past**	**Never**	
_____	_____	_____	Acne	_____	_____	_____	Epilepsy/Seizures
_____	_____	_____	Allergies	_____	_____	_____	Fatigue
_____	_____	_____	Anemia	_____	_____	_____	Frequent Infections
_____	_____	_____	Bed Wetting	_____	_____	_____	Headaches
_____	_____	_____	Birth Defects	_____	_____	_____	Heart Murmur
_____	_____	_____	Colic	_____	_____	_____	High Fever
_____	_____	_____	Constipation	_____	_____	_____	Hyperactivity
_____	_____	_____	Cough/Wheeze	_____	_____	_____	Insomnia
_____	_____	_____	Cradle Cap	_____	_____	_____	Jaundice
_____	_____	_____	Depression	_____	_____	_____	Learning Disorder
_____	_____	_____	Diarrhea	_____	_____	_____	Moodiness
_____	_____	_____	Dizzy Spells	_____	_____	_____	Stuffy Nose
_____	_____	_____	Earaches	_____	_____	_____	Vomiting Spells
_____	_____	_____	Eczema	_____	_____	_____	Other_____

What is your child's general disposition? _____

_____

_____

_____

Prenatal/Birth/Feeding History

1. Mother's health during pregnancy for this child (check, then describe below)

_____ Age	_____ Trauma/Injury	_____ Alcohol Consumption #/wk_____	
_____ Bleeding	_____ Stress	_____ Drugs	_____ Medications
_____ Nausea	_____ High Blood Pressure	_____ Smoking	Other_____
_____ Illness	_____ X-Rays	_____ Toxemia	

2. Term: Full_____ Premature_____ Late_____ Birth Weight_____

3. Was pregnancy easy? _____ Difficult? _____

Explain _____

4. Place of birth? Hospital _____ Home_____ Clinic_____ Other _____

5. Interventions at labor/birth:
_____ Pitocin _____ Epidural _____Demerol or other pain Rx
_____ Forceps_____ C-Section _____Vacuum extraction
6. Feeding: Breast fed Y N How long?_____ Cow's milk Y N How long? _____
Formula fed Y N How long?_____Type of formula_____
7. Age Solid Food Begun____ What foods?_____
Favorite Foods_____

Sample Daily Diet: (choose a typical day and include food and liquids)
Breakfast _____
Lunch _____
_____
Dinner _____
_____
Snack _____

Social History:
1. Parents: Married____ Partnership____ Separated____ Single_____Divorced_____
Parent's Occupation_____ Full / Part Time
Parent's Occupation_____ Full / Part Time
2. Other Guardian _____Relationship_____
3. Others residing in home _____ Relationship_____
4. Daycare/Preschool/School _____ Where _____
How many hours each day_____ Days of the week_____
5. Pets at home:_____

SIBLING(S): NAME AGE HEALTH PROBLEMS

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

REVIEW OF BODY SYSTEMS

Y: a condition now P: a condition of the past N: Never

MENTAL/EMOTIONAL

Mood Swings	Y P N	Anxiety/nervousness	Y P N
Irritability	Y P N	Cries easily	Y P N
Hyperactivity	Y P N	Unusual fears	Y P N
Introvert/extrovert	Y P N	Sleep Problems	Y P N
Motion/car sickness	Y P N	Nightmares	Y P N

ENDOCRINE

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

SKIN

Rashes	Y P N	Eczema, Hives	Y P N
Acne, Boils	Y P N	Itching	Y P N

HEAD

Headaches	Y P N	Head Injury	Y P N
Dizzy spells	Y P N	High fevers	Y P N

EYES

Glasses or contacts	Y P N	Tearing or dryness	Y P N
Eye pain/strain	Y P N		

EARS

Earaches	Y P N	Impaired hearing	Y P N

NOSE AND SINUSES

Frequent colds	Y P N	Noses Bleeds	Y P N
Stuffiness	Y P N	Hay fever	Y P N
Sinus problems	Y P N	Loss of smell	Y P N

MOUTH AND THROAT

Frequent sore throat	Y P N	Canker sores	Y P N
Breath odor	Y P N		

RESPITRATORY

Cough	Y P N	Wheezing	Y P N
Asthma	Y P N	Bronchitis	Y P N

CARDIOVASCULAR

Heart disease	Y P N	Murmurs	Y P N

URINARY

Frequent urination	Y P N	Bed wetting	Y P N
Kidney disease	Y P N	Bladder infections	Y P N

Y= condition now **P**= a condition in the past **N**= never had

GASTROINTESTINAL

Belching/passing gas	Y P N	Stomach aches	Y P N
Constipation	Y P N	Diarrhea	Y P N
Bowel Movements	How often_____		

MUSCULOSKELETAL

Joint pain/stiffness	Y P N	Muscle spasms/cramps	Y P N
Broken bones	Y P N		

BLOOD/PERIPHERAL VASCULAR

Anemia	Y P N	Easy bleeding/bruising	Y P N

Do you have any other health concerns you would like to discuss? Please explain

_____
_____
_____
_____
_____

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

_____
_____
_____
_____

Welcome! We're glad to be of service for you and your child!