Flagstaff Clinic of Naturopathic Medicine

705 N. Leroux St.
Flagstaff, AZ 86001
928-498-8777

Pediatric Intake form

Name:_____ D.O.B._____Age:_____Sex: F____M____

Address:_____

City:_____State:_____Zip:_____Home/cell phone:_____

Name of Parent or Guardian:_____

Address of Parent or Guardian:_____

City:_____State:_____Zip:_____Home/cell phone:_____

E-mail:_____Would you like to receive our newsletter: Y____N_____

Emergency contact:_____Emergency contact phone:_____

Primary care physician:_____

PCP address:_____

City:_____State:_____Zip:_____phone:_____

Insurance company:_____policy #:_____

Name of person insured:_____

How did you hear of us:_____Referred by:_____

Patient name:_____D.O.B.:_____

Reason for
visit:_____
_____
_____
_____

Last annual physical exam:_____Last blood work:_____

Last dental exam:_____Last eye exam:_____

Health history (check all that apply and list self or family member):

____Alcoholism_____
____Allergies_____
____Anemia_____
____Arthritis_____
____Asthma_____
____Cancer_____
____Colitis_____
____Diabetes_____
___ Drug abuse_____
____Heart disease_____
____Heart attack_____
____Herpes_____
____High blood pressure_____
____Hypoglycemia_____
____Liver diseases_____
____Mental illness_____
____Osteoporosis_____
____Stroke_____
____Thyroid_____
____Tuberculosis_____
Other (Please list):_____
_____

Previous major illnesses:_____

Does your child currently have any problems with the following:

____Breathing/Lungs
____Digestion/Bowels
____Dizziness/Fainting
____Eyes/Ears/Nose/Throat
____Glandular Swelling
____Headaches
____Heart/Circulation
____Frequent Infections
____Mood Changes
____Muscle Joints
____Skin
____Sleep
____Urination

Patient name:_____D.O.B.:_____

Hospitalizations/surgeries/injuries (dates and types of illness/operation):_____
_____
_____

Known allergies (medications, food, pollens, cleaning products, vaccinations, etc):_____
_____
_____

Medications currently taking (list type and dosage):_____
_____
_____

Supplements currently taking (list type and dosage):_____
_____
_____

Immunization history (Please list date of each vaccination/lab test and any reaction/result)

MMR:_____
DTP:_____
Haemophilus influenzae:_____
Hep A:_____
Hep B:_____
Influenza:_____
Pneumococcal:_____
Polio:_____
Tetanus:_____
Tetanus booster:_____
Smallpox:_____
Tuberculin:_____
Varicella:_____
Other:_____

Patient name:_____D.O.B.:_____

Birth location:_____

Sensitivities to odors:_____what type of odors:_____

Mercury fillings currently:_____recent chemical exposures:_____

Breast fed as a baby:_____Vaginal or C-section delivery:_____Complications_____

Birth weight:_____APGAR:_____

Parent: Please describe pregnancy (prenatal care, medications used, alcohol or drug use):

_____
_____
_____
_____
_____

Parent: Please describe feeding habits, disposition and overall health of your child from birth to 6 months old:

_____
_____
_____
_____
_____
_____

Thank you!