Heart Spring Health

Patient name: _____ Date of Birth: _____

Heart Spring Health | 819 SE Morrison St. Suite 115 Portland, OR 97214 | p. 503.956.9396 | f. 866.883.0582

Pediatric Intake Form

Child's Name: _____ Child's Age: _____ DOB: _____/_____/____ Date:_____

Child's Height: _____ Weight: _____ Male ❒ Female ❒ Grade Level: _____

Has any other family member been a client at the clinic? _____

How did you hear about us? (Referred by)_____ _____

**** Use final page if additional space is needed to answer any questions ****

Parents/Guardians

Name and relation to child: _____

Phone: (home) _____ (work) _____ (cell) _____

Address: _____

Email (for appointment reminder): _____

Name and relation to child: _____

Phone: (home) _____ (work) _____ (cell) _____

Address: _____

Message can be left at: _____ With: _____

Whom does the child live with? _____

Child's Other Health Care Providers:

Provider's name: _____Phone: _____

Designation/type of practice:_____

Last seen for what condition/date: _____

Health Concerns: *Please list the child's health concerns in order of importance.*

- Primary health concern: _____
- When did it begin? _____
- What do you think might be causing this condition? _____
- How has it been treated in the past and what was the effectiveness? _____
- Other Health Concerns:
  1. _____
  2. _____
  3. _____

Prenatal Health and History

- Mother's age at the time of the child's birth? _____
- How was the emotional and physical health of the parents at the time of conception?

  Mother: _____

  Father: _____
- How was the emotional and physical health of the mother during pregnancy? _____

Heart Spring Health

Patient name: _____ Date of Birth: _____

Heart Spring Health | 819 SE Morrison St. Suite 115 Portland, OR 97214 | p. 503.956.9396 | f. 866.883.0582

- How was the mother's diet during pregnancy? _____
- Describe any previous pregnancies, miscarriages, births and complications? _____

  _____
- Did mother experience any of the following during pregnancy? ❒ Bleeding ❒ High blood pressure ❒ Nausea ❒ Vomiting ❒ Diabetes ❒ Thyroid problems ❒ Physical or emotional trauma ❒ Illness ❒ Other: _____
- Did the mother use any of the following during pregnancy? ❒ Tobacco ❒ Alcohol ❒ Recreational drugs ❒ Prescription medication ❒ Over-the-counter medication ❒ Vitamins and/or supplements Please specify _____
- Medical tests during pregnancy? ❒ Ultrasound ❒Amniocentesis ❒ Chorionic Villi Sampling ❒ Triple Screen ❒ Maternal Serum Screening

Birth History

- Term length: _____ weeks ❒ Pre-term (37 weeks or less) ❒ Full-term (38-42 weeks) ❒ Post-term (more than 42 weeks)
- Location of birth: ❒ Hospital ❒ Home ❒ Birthing Center ❒ Other: _____
- Delivery was: ❒ Vaginal ❒ Scheduled C-section ❒ Emergency C-section ❒ Induced labor/Pitocin ❒ Forceps/Vacuum extraction ❒ Epidural/Anesthesia ❒ Episiotomy ❒ Other: _____
- Any complications before/during delivery (e.g., breech delivery)? _____
- Length of labor: _____ Weight of infant at birth: _____ APGAR score (0- 10): 1min. _____ 5 min. _____
- Did the child experience any of the following at or shortly after birth? ❒ Jaundice ❒ Rashes ❒ Seizures ❒ Birth injuries/defects ❒ Infections ❒ Difficulties with feeding ❒ Other _____

Dietary History

❒ Breastmilk exclusively until age _____ ❒Breastmilk with supplemental formula ❒ Not breastfed ❒ Started supplementary foods age _____

Weaned from the breast age _____ ❒ Formula (what types/when started) _____ ❒ Other: _____

- Did the infant have any colic or reflux, or other reactions to what was fed? _____
- Please describe foods introduced and what age, together with any reactions noted:

  0-6 months _____

  6-12 months _____

  12-18 months _____

  18+ months _____
- Please list any (known or suspected) food allergies or intolerances: _____
- Any dietary restrictions (vegetarian/vegan, religious, etc.)? _____
- Eating habits (good appetite, picky eater, tastes, textures, etc.)? _____

Medical History

- Has the child ever experienced any of the following illnesses? ❒ Rubella ❒ Mumps ❒ Whooping Cough ❒ Asthma ❒ Measles ❒ Chickenpox ❒ Scarlet Fever ❒ Polio ❒ Rheumatic Fever ❒ Other: _____
- Has the child received any of the following vaccinations? ❒ DPT ❒ MMR ❒ HIB ❒ Polio ❒ TB ❒ Flu ❒ Smallpox ❒ Pneumococcus ❒ Chickenpox ❒ Hepatitis ❒ Other: _____
- Did the child have any reactions following vaccination? _____
- Has the child ever been hospitalized? ❒Yes ❒No Why? _____ For how long? _____
- Has the child had any of the following tests? Please explain when and why they were taken:

Heart Spring Health

Patient name: _____ Date of Birth: _____

Heart Spring Health | 819 SE Morrison St. Suite 115 Portland, OR 97214 | p. 503.956.9396 | f. 866.883.0582

❒ CT Scan/X-ray/MRI _____

❒ Electroencephalogram _____

❒ Psychological evaluation _____

❒ Hearing evaluation _____

❒ Speech/Language evaluation _____

- Has the child ever had any physical or emotional traumas? _____

_____

General Review of Symptoms Y = a condition your child has now N = never had P = has had in the past, even as a baby

Hives or Rashes	Y	N	P	Ear infections (how many)	Y	N	P	Vomiting	Y	N	P
Eczema	Y	N	P	Hearing loss	Y	N	P	Constipation	Y	N	P
Acne	Y	N	P	Frequent urination	Y	N	P	Loss of appetite	Y	N	P
Frequent colds	Y	N	P	Burning or bloody urine	Y	N	P	Body/breath odor	Y	N	P
High fever	Y	N	P	Bedwetting	Y	N	P	Jaundice	Y	N	P
Cough/Croup/Wheezing	Y	N	P	Nervous or moody	Y	N	P	Anemia	Y	N	P
Bronchitis/Pneumonia	Y	N	P	Cries easily	Y	N	P	Bleeding/Bruising	Y	N	P
Frequent sore throats	Y	N	P	Unusual fears	Y	N	P	Fatigue	Y	N	P
Frequent headaches	Y	N	P	Sensitivity to heat or cold	Y	N	P	Night sweats	Y	N	P
Bleeding gums or nose	Y	N	P	Stomach aches	Y	N	P	Heart murmur	Y	N	P
Allergies	Y	N	P	Gas/colic	Y	N	P	Joint pains	Y	N	P
Dizzy spells	Y	N	P	Diarrhea	Y	N	P	Developmental issues	Y	N	P

Medication History

❒ Aspirin ❒ Tylenol ❒ Ibuprofen/Advil ❒ Antibiotics ❒ Decongestant ❒ Anti-histamine ❒ Topical steroids ❒ Inhalers

❒ Asthma meds ❒ Aspirin or Tylenol (specifically for fever)

- Please list any medications and/or supplements the child is currently taking: _____
- Does the child have any known drug allergies? ❒Yes ❒No If yes, please list drug allergies: _____

Health and Development

- How was the child's health in the first year? _____
- How is the child's health now? _____
- At what age did the child first: Sit up _____ Crawl _____ Walk _____ Talk _____
- How was toilet training? _____
- Was teething early, late or typical? Difficult? _____

Sleep Patterns

- What time does the child usually go to bed? _____
- What time does the child usually wake in the morning? _____
- Does the child nap during the day? ❒Yes ❒No What time(s) do they nap?_____
- Does the child have nightmares? ❒Yes ❒No Please describe? _____

Heart Spring Health | 819 SE Morrison St. Suite 115 Portland, OR 97214 | p. 503.956.9396 | f. 866.883.0582

- Does the child have any problems associated with sleeping? ❒Yes ❒No
- If yes, what kind of trouble do they have (e.g., trouble falling asleep, trouble waking up, etc.)?_____

Social Patterns

- Is the child in: ❒School ❒Daycare ❒Home care ❒Other: _____
- How would you describe the child's behavior at school? _____
- How would you describe the child's behavior at home? _____
- What are the child's interests and favorite activities?_____
- What recreational activities is the child involved in? _____
- How would you describe the child's temperament/personality? _____
- Is there anything that you would want to change?_____
- How much and how often does the child exercise? _____
- How often does the child read, **or** does someone read to the child? ❒ Daily ❒ Several times a week ❒Weekly ❒ Less than weekly
- How much television does the child watch? _____ hours a day/week

Family History Please indicate if a close relative (parent, grandparent, sibling) has any of the following:

Condition	Relative	Condition	Relative	Condition	Relative
❒ Allergies/Hay fever		❒ Eczema/Psoriasis		Depression/Anxiety	
❒ Anemia		❒ Food Intolerances		Diabetes	
❒ Arthritis		❒ Heart Disease		Stroke	
❒ Asthma		❒ High Blood Pressure		Tuberculosis	
❒ Autoimmune Disease		❒ Juvenile Arthritis		Cancer	
❒ Birth Defects		❒ Kidney Disease		Seizures	
❒ Bleeding Disorder		❒ Mental Illness		Other:	

❒ I don't know the family medical history

- Do either of the parents of the child have a chronic illness? ❒Yes ❒No If yes, please describe: _____

_____

Environment

- Does anyone in the child's household smoke? ❒Yes ❒No
- Are there any pets in the home? ❒ Yes ❒No If yes, what type and how many? _____
- How is the child's home heated? _____
- How would you describe the emotional climate of the child's home? _____
- Do you know of any toxins or other hazards that the child is regularly exposed to? ❒yes ❒no

  If yes, please describe: _____
- Does the child have any known environmental or chemical sensitivities (e.g., perfumes, detergents, odors, soaps, etc.)?

  _____
- Is there anything that you feel is important that has not been covered? _____

Heart Spring Health

Patient name: _____ Date of Birth: _____

Heart Spring Health | 819 SE Morrison St. Suite 115 Portland, OR 97214 | p. 503.956.9396 | f. 866.883.0582

Diet Diary:

Below is a Diet Diary. Please list, in the spaces provided, every food item that the child puts into their mouth for a 7 day period. Please take note of any physical symptom or sensitivities that they may experience during this exercise and note them in the 'notes' section provided.

Diet Diary

	Breakfast	Lunch	Dinner	Snacks	Notes