Dr. Cheri King
NATUROPATHIC DOCTOR

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Pediatric Patient Intake Form
(2-12 years old)

Last Name: ___________________ First Name: _____________________ Gender (sex): __________

Date of birth: __________ Age: ______ Email: ____

Mother's Name: _____________________ Mother Phone #: _________________________________

Father's Name: ______________________ Father Phone #: _________________________________

Address: _____________________________City: _______________ State: ______ Zip: __________

How did you hear about us? ____

*Email will only be used to contact you or to send you newsletters. It will not be shared with anyone.

HEALTH HISTORY QUESTIONNAIRE

Birth city & state: _____________________ Birth time: __________ Birth weight: _______________

Weeks in gestation: __________________ Vaginal / Caesarean Delivery: ______________________

Breast-fed? _____ How long? ___________ Formula? _____________ Milk / Soy _______

Is there anything significant about the birth? ____

Has your child had any dental work? If so, what? ____

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

1.____

2.____

3.____

Does your child have a contagious disease at this time? Y N

If yes, what? ____

PREVIOUS ILLNESSES

	Month/Year		Month/Year
Rheumatic Fever		German Measles	
Chicken Pox		Measles	
Tonsillitis		Ear Infections	
Other		Other	

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Has your child had any of the following tests?

	When	**Where**
Electroencephalogram (EEG)		
Psychological evaluation		
Hearing tests		
Speech/Language tests		

What hospitalizations, surgeries or injuries has your child had?
____

____

____

IMMUNIZATIONS

√	**Vaccine**	**Date(s) in Month/Year**
	Diphtheria-tetanus-acellular pertussis (DTaP)	
	Inactivated polio vaccine (IPV)	
	Measles-mumps-rubella (MMR)	
	Varicella (chickenpox)	
	Haemophilus influenzae type b (Hib)	
	Pneumococcal conjugate (PCV13) or polysaccharide (PPSV23)	
	Hepatitis B (Hep B)	

Were there any adverse reactions?

If yes, what? ____

ALLERGIES

Is your child hypersensitive or allergic to:

Any drugs? ____

Any foods? ____

Any environmental? ____

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MEDICATIONS & SUPPLEMENTAL NUTRIENTS

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

1) ______________________________ 5) ______________________________

2) ______________________________ 6) ______________________________

3) ______________________________ 7) ______________________________

4) ______________________________ 8) ______________________________

TYPICAL FOOD & DRINK INTAKE

Breakfast: ______________________________

Lunch: ______________________________

Dinner: ______________________________

Snacks: ______________________________

To Drink: ______________________________

REVIEW OF SYSTEMS

Please circle any symptoms your child has experienced:

Mental/Emotional	Endocrine	Skin	Head & Eyes	Ears, Nose & Sinuses
Mood Swings Irritability Hyperactivity Introvert/Extrovert Motion/Car Sickness Anxiety/Nervousness Cries Easily Unusual Fears Sleep Problems Nightmares	Heat Intolerance Cold Intolerance Fatigue Excessive Thirst Excessive Hunger Low Blood Sugar High Blood Sugar	Rashes Eczema, Hives Acne, Boils Itching	Headaches Head Injury Dizzy Spells High Fevers Glasses or Contacts Tearing or Dryness Eye Pain/Strain	Earaches Impaired Hearing Frequent Colds Nose Bleeds Stuffiness Hay Fever Sinus Problems Loss of Smell
Mouth & Throat	**Respiratory**	**Cardiovascular & Blood**	**Urinary & Gastrointestinal**	**Musculoskeletal**
Frequent Sore Throat Canker Sores Breath Odor	Cough Wheezing Asthma Bronchitis	Heart Disease Murmurs Anemia Easy Bleeding Bruising	Frequent Urination Bed Wetting Belching/Flatulence Stomach Aches Constipation Diarrhea	Joint Pain/Stiffness Muscle Spasms Muscle Cramps Broken Bones

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