



## CHILD INTAKE FORM (0-18 yrs)

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Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Parent/Guardian Cell Phone: \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Gestational Age: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Email: \_\_\_\_\_

Who referred you to us? \_\_\_\_\_

Pediatrician/Medical Doctor's Name: \_\_\_\_\_

Pediatrician/Medical Doctor's Phone Number: \_\_\_\_\_

Pediatrician/Medical Doctor's Address: \_\_\_\_\_

Who is filling out this form (name and relation)? \_\_\_\_\_

Reason for coming to office today:  
\_\_\_\_\_  
\_\_\_\_\_

Child's Health Concerns, in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

### Mother's Profile

Mother's Name: \_\_\_\_\_

Mother's Age: \_\_\_\_\_ Present Health Status: \_\_\_\_\_

Any Prior Medical-Surgical Events (none or list): \_\_\_\_\_

Are you a smoker?  Yes  No If yes, how many cigarettes per day? \_\_\_\_\_

Do you consume any alcohol?  Yes  No If yes, how much per week? \_\_\_\_\_

Are you working presently?  Yes  No  FULL-TIME  PART-TIME

What is your stress level? Please rate on a scale of 1 (least) to 10 (most): \_\_\_\_\_

Date of Last Menstrual Period: \_\_\_\_\_

Describe your previous pregnancies (any anxieties, complications):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Prenatal History**

Duration of Pregnancy: \_\_\_\_\_ How was the child conceived? \_\_\_\_\_

Did you have prenatal medical supervision?  Yes  No

List any illnesses, infections, complications during pregnancy:  
\_\_\_\_\_

Treatments/ Medications During Pregnancy (check):

- Tobacco  Alcohol  Recreational Drugs: List \_\_\_\_\_
- Prescription/ Over-The-Counter Drugs: \_\_\_\_\_
- Supplements/ Others: \_\_\_\_\_

Did you take Prenatal Classes?  Yes  No

Planned or unplanned pregnancy? \_\_\_\_\_

Helping persons available during pregnancy: \_\_\_\_\_

Describe your diet during the pregnancy. Indicate cravings also.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How much weight did you gain? \_\_\_\_\_

Did you experience any of the following (check):

- nausea  vomiting  high blood pressure  diabetes
- physical or emotional trauma
- other \_\_\_\_\_

Describe your reaction when you first felt the baby move.  
\_\_\_\_\_

Any past miscarriages?  Yes  No If yes, when: \_\_\_\_\_

**Labor and Delivery History**

Birth Weight: \_\_\_\_\_ Birth Height: \_\_\_\_\_

Duration of Labor: \_\_\_\_\_

Type of Delivery (natural vaginal / C-section): \_\_\_\_\_

Medications and Anesthesia (types, durations, any reactions):  
\_\_\_\_\_

Were any of the following used?

- episiotomy  forceps  vacuum  epidural  other: \_\_\_\_\_

Any complications (none or list)? \_\_\_\_\_

Fluids-blood loss (how much): \_\_\_\_\_

Attended by significant other?  Yes  No

Held and/or nursed baby on delivery table?  Yes  No

APGAR score: \_\_\_\_\_

Any congenital abnormalities (none or list):

**Father's Profile**

Father's Name: \_\_\_\_\_

Father's Age: \_\_\_\_\_ Present Health Status: \_\_\_\_\_

Any Prior Medical-Surgical Events (none or list): \_\_\_\_\_

Are you a smoker?  Yes  No If yes, indicate how many cigarettes per day: \_\_\_\_\_

Do you consume any alcohol?  Yes  No If yes, indicate how much per week: \_\_\_\_\_

Are you working presently?  Yes  No  FULL-TIME  PART-TIME

What is your stress level? Please rate on a scale of 1 (least) to 10 (most): \_\_\_\_\_

**Child's Profile**

*A. Medical History:*

Any medical conditions (illnesses, injuries, etc.) (If in past, please provide date):

past \_\_\_\_\_ present \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Childhood Illnesses:

If child has had any of the following in the past, please provide date of occurrence.

Name	Date
Rubella	
Measles	
Mumps	
Roseola	
Chicken Pox	
Strep Throat	
Rheumatic Fever	
Scarlet Fever	
Impetigo	
Ear Infections (also state how often)	

Current and Past Medications and/or Supplements (indicate brand and dose, for how long):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Vaccination History (check and provide date):

DPT (diphtheria, pertussis, tetanus), when: \_\_\_\_\_

Tetanus booster, when: \_\_\_\_\_

MMR (measles, mumps, rubella), when: \_\_\_\_\_

Polio, when: \_\_\_\_\_

Flu shot, when: \_\_\_\_\_

Haemophilus influenza B, when: \_\_\_\_\_

Hepatitis A, when: \_\_\_\_\_

Hepatitis B, when: \_\_\_\_\_

Others: \_\_\_\_\_

List any adverse reactions:  
\_\_\_\_\_  
\_\_\_\_\_

Accidents and injuries (what and when):  
\_\_\_\_\_  
\_\_\_\_\_

Hospitalizations and surgeries (for what reason and when):  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have any allergies? (medicines, environment, etc.)  
\_\_\_\_\_  
\_\_\_\_\_

*B. Feeding/ Nutritional History:*

- breastfed for how long: \_\_\_\_\_
- formula at what age: \_\_\_\_\_
- what kind of formula (milk, soy, other): \_\_\_\_\_
- reactions to any formulas?      Yes / No      If yes, describe: \_\_\_\_\_

Food Introduction Schedule:  
- list foods that were introduced and at which month:

Age of Food Introduction							
Type of Food Introduced							

*Diet:*

Describe your child's appetite:  
\_\_\_\_\_  
\_\_\_\_\_

Please give a 24-hr diet recall for the child:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Cups of water drank in a day: \_\_\_\_\_

Food preferences and dislikes? \_\_\_\_\_

*C. Sleeping Patterns:*

When does the child go to bed? \_\_\_\_\_ When does he/she wake up? \_\_\_\_\_

Does the child wake up in the night?     Yes     No    If yes, how often: \_\_\_\_\_

Does your child take naps?                 Yes     No    If yes, how long are naps: \_\_\_\_\_

*D. Developmental milestones:*

When did child first: sit up \_\_\_\_\_ crawl \_\_\_\_\_ walk \_\_\_\_\_ talk \_\_\_\_\_  
be fully toilet- trained \_\_\_\_\_ brush own teeth \_\_\_\_\_

*E. Family History (include chronic, inherited conditions, allergies, causes of death, illnesses):*

<i>Relative</i>	<i>Condition(s)</i>
Mother	
Father	
Sibling #1	
Sibling #2	
Sibling #3	
Sibling #4	
Grandparents	
Other	

*F. Psychosocial/ Overall Health:*

Child's Hobbies and Enjoyed Activities:

\_\_\_\_\_

\_\_\_\_\_

How often does your child watch TV/ play video games? (check day or week) \_\_\_\_\_ hrs a  day /  week

Is your child in (check):  school  daycare  other \_\_\_\_\_

Current School: \_\_\_\_\_

Grade: \_\_\_\_\_

How would you describe your child's performance and behaviour at school?

\_\_\_\_\_

Does your child exercise regularly?  Yes  No If yes, what type of exercise, how much and how often:

\_\_\_\_\_

**Home/ Environment Profile**

Describe home preparations made for the new baby.

\_\_\_\_\_

\_\_\_\_\_

Describe how bringing home a new baby changed the life of each member of the family.

\_\_\_\_\_

\_\_\_\_\_

Position of child in family: \_\_\_\_\_

Number of people in the home: \_\_\_\_\_

Who is the primary caregiver(s)? \_\_\_\_\_

Other caretakers for child: \_\_\_\_\_

Does anyone in the home smoke?  Yes  No

Do you know of any toxins or hazards that your child is exposed to regularly (home, hobbies, etc.)?

\_\_\_\_\_

Any pets in the home?  Yes  No If yes, list: \_\_\_\_\_

How old is the house the family is living in? \_\_\_\_\_

Has it been recently renovated?  Yes  No

## Review of Systems

Circle the symptoms child has experienced check *N* if currently experiencing it or *P* if in past.

General:      headache      fever/ chills      fatigue/ weakness      dizziness  
                   P  N       P  N       P  N       P  N

Hair and Scalp:    dandruff              lice      cradle cap      itchiness      hair loss  
                           P  N       P  N       P  N       P  N       P  N

Skin:      infections      rashes      scaling      bruising      bleeding  
                   P  N       P  N       P  N       P  N       P  N

Eyes:      infections      blurred vision      eyeglasses (nearsighted, farsighted)  
                   P  N       P  N       P  N

                  Squinting      color blindness  
                           P  N       P  N

Ears:      infection      discharge      wax      decreased hearing      foreign objects  
                   P  N       P  N       P  N       P  N       P  N

Nose, throat, sinuses:    runny nose      colds      decreased smell      foreign objects      bloody nose  
                                   P  N       P  N       P  N       P  N       P  N

                                  Tonsillitis  
                                   P  N

Mouth and dentition:      caries              gingivitis              cleft lip      palate  
                                   P  N       P  N       P  N       P  N

Respiratory:      bronchitis      pneumonia      asthma      cough      sputum  
                           P  N       P  N       P  N       P  N       P  N

Cardiovascular:      heart murmurs      cyanosis      palpitations      rheumatic fever  
                                   P  N       P  N       P  N       P  N

Gastrointestinal:      nausea      vomiting      diarrhea      constipation      jaundice  
                                   P  N       P  N       P  N       P  N       P  N

                                  colic              gas              anorexia      blood in stool  
                                   P  N       P  N       P  N       P  N

Urinary:    increased frequency      urgency      burning      bedwetting  
                                   P  N       P  N       P  N       P  N

                          odor              blood in urine      hesitancy  
                                   P  N       P  N       P  N

Male Reproductive:    hernias      testicular mass      testicular pain      penile discharge  
                                   P  N       P  N       P  N       P  N

Female Reproductive:    menses              vaginal itching              vaginal discharge  
                                   P  N       P  N       P  N

Neuromuscular:    seizures      muscle weakness      numbness      tremors      imbalance  
                                   P  N       P  N       P  N       P  N       P  N

Blood/ Lymphatics:    anemia      easy bleeding      easy bruising      swollen lymph node  
                                   P  N       P  N       P  N       P  N

Emotional:      mood swings      nervousness      depression/ sadness  
                                   P  N       P  N       P  N

**ADOLESCENCES ADDENDUM** (13- 18 yrs)

To be filled out by patient if between the age of 13-18.

**Medical History:**

What are your health concerns, in order of importance?

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

Do you do/ take any of the following (check)?

- smoke, if so, how many packs per (circle) day / week \_\_\_\_\_
- alcohol, if so, how much and how often \_\_\_\_\_
- recreational drugs, if so, how much and how often \_\_\_\_\_
- others \_\_\_\_\_

**Psychosocial:**

How would you describe your

- relationship with parents:     Excellent             Good             OK             Poor
- relationship with siblings:    Excellent             Good             OK             Poor
- relationship with friends:     Excellent             Good             OK             Poor

Do you enjoy school?    Yes    No

What do you like/ dislike about school?

What is your stress level? Please rate on a scale of 1 (least) to 10 (most) for the following:

Home: \_\_\_\_\_ School: \_\_\_\_\_ Other (list): \_\_\_\_\_

List extra-curricular activities and hobbies: (sports teams, bands, piano lessons, etc.):

List your goals (future goals, career, etc.):

How much TV do you watch? (check day or week) \_\_\_\_\_ hrs a  day /  week

How often do you play video games? \_\_\_\_\_ hrs a  day /  week

How often do you use the internet/ computer? \_\_\_\_\_ hrs a  day /  week

Do you exercise? Yes / No    If yes, what type of exercise, how much and how often:

**MALE**

Age of onset of puberty: \_\_\_\_\_

Have you noticed any change in the penis and scrotum? \_\_\_\_\_

Are you familiar with normal growth patterns, nocturnal emissions ("wet dreams"), and sex education?

**FEMALE**

When did you notice your breasts were changing? \_\_\_\_\_

How old were you when you had your first period? \_\_\_\_\_

Average # of bleeding days (period) \_\_\_\_\_ Average # of days between bleeding \_\_\_\_\_

Is there bleeding between periods? \_\_\_\_\_

**Sexual History:**

Are you sexually active?  Yes    No    If yes, please continue.

What type of birth control do you use (none or list)?

Have you been tested for STD's/ venereal diseases?  Yes    No    If yes, which ones?

Sexual Preference (check mark):     Heterosexual     Bisexual             Homosexual

Female: When was your last PAP test? \_\_\_\_\_

Female: Have you ever been pregnant, had a live birth, miscarriage or abortion?

Is there anything you feel is important that has not been addressed?