**Julianne M. Forbes, N.D.**
**P.O. Box 167**
**North Bridgton, ME. 04057**
**207-647-9423, FAX: 207-647-3669**

# PEDIATRIC INTAKE FORM (6-12)

Name_____ Date_____

Age_____ Date of Birth___/____/____ female_____ male_____

Mother's name_____ Father's name_____

Address_____

City_____ State_____ Zip Code_____

Telephone # (home) _____email _____

How did you hear about this clinic_____

## HEALTH HISTORY QUESTIONAIRE

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

1)_____
2)_____
3)_____
4)_____

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

If yes, what? _____

**Previous Illnesses**

| | | | |
|---|---|---|---|
| Rheumatic fever | Y N | German measles | Y N |
| Chicken Pox | Y N | Measles | Y N |
| Tonsillitis | Y N | approx. number_____ | |
| Ear infections | Y N | approx number _____ | |
| Other | Y N | list_____ | |

Has your child had any of the following tests? When Where

Electroencephalogram (EEG)

……....

Psychological evaluation

…….

Hearing tests

…….

Speech/Language tests

…….

**Hospitalizations/ Surgeries/ Injuries**

What hospitalizations, surgeries or injuries has your child had?

---

---

---

**Immunizations**

| | | | |
|---|---|---|---|
| Polio | Y N | Pertussis | Y N |
| Tetanus shot | Y N | Diphtheria | Y N |
| Measles/Mumps/Rubella | Y N | Influenza | Y N |
| Adverse reactions | Y N | If yes, what? _____ | |

**Allergies**

Is your child hypersensitive or allergic to?

Any drugs?_____

Any foods?_____

Any environmentals? _____

Breast fed? _____ how long?_____ Formula?_____ milk/soy _____

**Typical Food Intake**

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

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

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

## REVIEW OF SYSTEMS

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

### 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 |

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

### CARDIOVASCULAR

| | | | |
|---|---|---|---|
| Heart disease | Y P N | Murmurs | Y P N |

**URINARY**

| | | | |
|---|---|---|---|
| Frequent urination | Y P N | Bed wetting | Y P N |

**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 |

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!**