A Natural Path Integrated Health Services
Kathleen Flewelling ND
Telephone: 503-738-5859 Fax: 503-738-7726
620 S. Holladay Dr. Suite 6 Seaside, OR 97138

Pediatric Intake Form

Child's Name____________________________________Age_______ Sex__________ Birth date__________

Address___________________________________City_________State________________Zip__________

Telephone (Home)__________________________________

Social Security Number______________________

With whom does this child live with (circle)? Mother Father Other (List)____________________

Guardian Information:
Name____________________________________Relationship______________________________

Who has permission to bring in your child to my office for treatment?
Name Relationship to child Phone#

____

____

Date of last physical exam________________________
What are your top three health concerns for your child?
1.____

2.____

3.____
Where was your child born?
Home ________Hospital______Birth Center__________

Was your child breastfed?__________How long?__________

Current Medications: Medications currently using including presciption, over the counter, herbal and vitamins. Please include how long your child has been using them. Use a separate sheet if needed.

1. ____________________________________ 3.____

2. ____________________________________ 4.____

What vaccines has your child had and if applicable, dates:
DPT______________________
DT_______________________
Tetanus only_________________
HEP B_____________________
HEP A_____________________
HIB_______________________
Polio______________________
MMR______________________
Chicken Pox_________________
HPV_______________________
Other (List)_________________

Allergies

Does your child have any allergies or sensitivities to medications or substances?_____Yes______No

List____

Does your child have any allergies or sensitivities to any chemical or environmental toxins?___Yes____No

List____

What happens when your child has an allergy attack?_____________________________________

____

Health History

Has your child had any of the following conditions in the past or currently?

Condition	In the Past	Currently
Asthma		
Ear Infection __		
Eczema		
Rashes		
Allergies		
Chicken Pox		
Bladder Infection		
Colic		
Bronchitis		
Strep Throat		
Constipation		
Other __		

Family History

Please mark any illnesses that have occurred in any of your blood relatives and if applicable list the relationship to the child.

Yes	Relation	Yes	Relation	Yes	Relation
___Diabetes		___Scarlet Fever		___Anemia	
___Thyroid Problems		___Alcoholism		___Arthritis	
___High Blood Pressure		___Gout		___AIDS	
___Hemophilia		___Venereal Disease		___Aneurysm	
___Mental Illness		___Lung Disease		___Drug Addiction	
___Stroke		___Heart Disease		___Eating Disorder	
___Kidney Disease		___Tuberculosis		___Epilepsy/Seizures	
___Asthma/Allergies				___Glaucoma	
___Cancer		Type of cancer?______________			

Whom may we thank for this referral?______________________________

Has you or your child used alternative care in the past?______________

For what?____

______________________________   ______________

Signature of Parent or Guardian   Date