Dr. Jeannie Achuff, ND
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(778) 265-6666
originsofhealthnaturalmedicine.com

PEDIATRIC INTAKE FORM (6 to 12 years)

Patient's name: _____ Date of first visit: _____

Age: _____ Date of Birth (month/day/year): _____/_____/_____ Gender: ☐ female ☐ male

Mother's name:_____ Father's name: _____

Address: _____ City: _____ Province: ___ Postal Code: _____

Phone number (home): (_____)_____ Parent's work phone number (_____)_____

Parent's e-mail address: _____

How did you hear about Dr. Achuff? _____

Child's GP or Pediatrician: _____

Child's medical specialist(s): _____

Current health concerns: _____

_____

MEDICAL HISTORY

_____ Chicken pox	_____ Scarlet fever	_____ Roseola	_____ Mononucleosis
_____ Measles	_____ Pneumonia	_____ Strep throat	_____ Impetigo
_____ Mumps	_____ Whooping Cough	_____ Ear Infections	
_____ Rubella	_____ Rheumatic fever	_____ other (please list) _____	

What screening tests has your child had? (blood, hearing, vision, etc)_____

Serious Illnesses/Injuries/Surgeries/Hospitalizations (please list): _____

_____

Please list all current medications (prescription, over the counter, vitamins, herbs, homeopathics, etc.)

_____

Has your child been treated with antibiotics? ☐ yes ☐ no If yes, how many times: ____ Most recent date:_____

Please list any other past prescription medications: _____

IMMUNIZATIONS

_____ MMR	_____ Polio	_____ MMR	_____ Smallpox	_____ H. Influenza B
_____ DPT	_____ Influenza	_____ Hepatitis B	_____ Hepatitis A	_____ Other: _____

Any adverse reactions to vaccines: ☐ yes ☐ no If yes, please describe:_____

FAMILY HISTORY (if known)

___Heart disease	___Diabetes	___Birth abnormality	___ Celiac disease	Other: _____
___Hypertension	___Arthritis	___Tuberculosis	___ Eczema	Other: _____
___Cancer	___Allergies	___Mental illness	___ Asthma	Other: _____

Child's sleep patterns _____ _____

How would you describe your child's temperament?_____

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

_____

Does your child exercise regularly? ☐ yes ☐ no If yes, how often? _____

Food or environmental allergies (if known) _____

Any dietary restrictions (religious, vegetarian, vegan, etc.)? _____

Describe child's typical daily diet:
Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages (type and quantity) _____

SYMPTOMS (mark **Y** if current, **P** significant past symptom)

_____ Hives	_____ Burning of urine	_____ Bloody urine
_____ Eczema	_____ Frequent urination	_____ Cries easily
_____ Bleeding gums	_____ Heart murmur	_____ Nervous
_____ Nose bleeds	_____ Vomiting spells	_____ Sleep problems
_____ Acne	_____ Anemia	_____ Night sweats
_____ High fevers	_____ Stomach aches	_____ Sensitive to light
_____ Chronic rash	_____ Jaundice	_____ Body/breath odor
_____ Hearing loss	_____ Easy bruising	_____ Motion/car sickness
_____ Diarrhea	_____ Flat feet	_____ No appetite
_____ Sore throats	_____ Constipation	_____ Nightmares
_____ Headaches	_____ Gas	_____ Canker sores
_____ Frequent colds	_____ Bleeding tendency	_____ Unusual fears
_____ Wheezing	_____ Joint pains	_____ Excessive fatigue
_____ Cough	_____ Dizzy spells	_____ Hair loss

Other: _____

What expectations do you have from this visit with Dr. Achuff?

What long-term expectations do you have for working with Dr. Achuff?

CONSENT AND CANCELLATION POLICY
I hereby consent to receive treatment by Dr. Achuff. I understand that I am responsible for paying the full cost of treatment if I do not give 24 hours notice of change or cancellation.

EMAIL CORRESPONDENCE (we will not sell, rent, or share your email address)

☐ Yes ☐ No - Dr. Achuff may correspond with me at the above email address.

Signature: _____ Today's date: _____
(Parent or Guardian)

Thank you. We look forward to helping your child in any way we can.

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