Zepp Wellness
healing, naturally.

PEDIATRIC INTAKE FORM (AGES 12 AND UNDER)

Child's Name: ______________________________

Date of birth (dd/mm/yyyy): ______________________________

Full address: ______________________________

Parents' Name (s): ______________________________

Telephone: (home) ____________________(work)____________________

Other health care providers

1. ____________________ 2. ____________________ 3. ____________________
____________________ ____________________ ____________________
____________________ ____________________ ____________________
(_____)______________ (_____)______________ (_____)______________

Health Concerns

What are your child's health concerns, in order of importance:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

How would you describe your child's general state of health? Excellent Good Fair Poor

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

____
____
____
____

Medical History

How was your child's health in the first year of life?Poor Fair Good Excellent Unknown

____
____

Please list past prescription medications.

____

____

____

____

How many times has your child been treated with antibiotics? __________

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates:

____

____

____

____

Which of the following has your child had? (n – never, m – mild, a – average, s – severe)

n m a s rubella (german measles)	n m a s roseola	n m a s impetigo
n m a s measles	n m a s scarlet fever	n m a s mononucleosis
n m a s chicken pox	n m a s whooping cough	n m a s ear infections
n m a s mumps	n m a s strep throat	

Does your child have any allergies (medicines, environmental, etc.)?

____

____

Please indicate what immunizations your child has had

☐ DPT (diphtheria, pertussis, tetanus)	☐ Haemophilus influenza B	☐ Polio
☐ Tetanus booster; when? ______________	☐ Hepatitis B	☐ Hepatitis A
☐ MMR (measles, mumps, rubella)	☐ Influenza	☐ Mennigococal
☐ Chicken pox	☐ Prevar	☐ Rotavirus
☐ HPV (Guardasil)	☐ H1N1	

Other ____

Please indicate if any caused adverse reactions

____

____

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

____

____

Family History

Please put an "L" for living and "D" for deceased, and present age or age at the time of death.

Relationship	L/D	Age	Diseases Suffered/ Cause of Death
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Father			
Mother			
Brother			
Brother			
Sister			
Sister			
Paternal Uncles			
Paternal Aunts			
Maternal Uncles			
Maternal Aunts			

Prenatal History

What was the health of the parents at conception?

Mother Poor Fair Good Excellent Unknown

Father Poor Fair Good Excellent Unknown

What was the health of the mother during the pregnancy?

Poor Fair Good Excellent Unknown

How was the mother's diet during pregnancy?

Poor Fair Good Excellent Unknown

Did the mother receive prenatal medical care? Y N Unknown

Did the mother experience any of the following during the pregnancy:

☐ Bleeding ☐ High blood pressure ☐ Nausea ☐ Vomiting

☐ Diabetes ☐ Thyroid problems ☐ Physical or emotional trauma

Other ____

____

Did the mother use any of the following during the pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational drugs:____

☐ Prescription medications:____

☐ Over-the-counter medications:____

☐ Supplements:____

☐ Other: ____

Birth History

Term length: ☐ Full ☐ Premature: ________ wks ☐ Late: ________ wks

Length of labour: ________________ Weight at birth _____________

Any complications?____

Was the birth: Vaginal/C-section Induced Forceps Anesthesia used

Did your child experience any of the following at or shortly after birth?

☐ Jaundice ☐ Rashes ☐ Seizures ☐ Birth injuries____

☐ Birth defects____

☐ Other ____

Dietary Habits

How was your infant fed?

☐ Breast fed. How long? ____________ ☐ Formula. Milk/Soy/Other: ____________

☐ Other: ____

What foods were introduced before 6 months? (Please list approximate month as well.)

____

____

____

6–12 months?

____

____

____

____

Did your child ever experience colic? Y N How severe? mild moderate severe

Does your child have any food allergies or intolerances? Please list.

____

____

____

____

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)?

____

____

Describe a typical day's diet

Breakfast ____

Lunch ____

Dinner ____

Snacks ____

Beverages (and total quantity)____

Environment

Is your child in school daycare home care other____

What are your child's favorite activities?____

____

Does your child exercise regularly? Y N How much, how often?

____

____

How much television does your child watch? _________ hrs a day/week

How often does your child read (not for school), or How often does someone read to your child?

☐ Daily ☐ Several times a week ☐ Weekly ☐ Less than weekly

Does anyone in your child's household smoke? Y N

Are there animals in the home? Y N

How is your child's home heated?____

Do you know of any toxins or other hazards your child is regularly exposed to (home, other's work, hobbies, etc.)? Please describe.

____

____

____

____

How would you describe the emotional climate of your child's home?

____

____

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

____

____

____

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