Paul Raish, ND 215 S. Complex Drive, Kalispell, 59901

PEDIATRIC INTAKE

(This is a confidential medical record and will not be released without your authorization) *Please print clearly and mail back to clinic prior to first office visit. Thank you for your time and effort. We look forward to providing you with the best possible care.*

Patient Name _____ Date _____
Age _____ DOB _____ Gender: Female
Parent/Guardian Name _____
Address _____
City/State/Zip _____
Phone: Home: (____) ____ - _____ Parent's Work: (____) ____ - _____
Parent's E-mail: _____
May we leave messages on your: ☐ home phone ☐ work phone ☐ email
Please tell us how you found out about our office or who you were referred by:

Is your child currently being seen by other health practitioners? (Please list names & phone # if avail.)

Reason for referral or presenting problems:

Medications (please check)

NOW	PAST		NOW	PAST	
☐	☐	Aspirin	☐	☐	Decongestants
☐	☐	Tylenol	☐	☐	Antihistamine
☐	☐	Ibuprofen	☐	☐	Other _____
☐	☐	Antibiotics	**Allergies to medicines**: _____		

Medical History

☐ Chicken pox	☐ Scarlet fever	☐ Tonsillitis, approx. number of times: _____
☐ Measles	☐ Pneumonia	☐ Ear infections, approx. number of times: _____
☐ Mumps	☐ Frequent colds	☐ Strep throat, approx. number of times: _____
☐ Rubella	☐ Rheumatic fever	☐ Other: _____

Immunizations

☐ MMR	☐ DPT	☐ Chicken pox Others _____
☐ Measles	☐ Diphtheria	☐ Small pox /Adverse reactions: No
☐ Mumps	☐ Tetanus	☐ H. influenza If so, what? _____
☐ Rubella	☐ Polio	☐ the Flu _____

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Family History

☐ Heart disease	☐ Diabetes	☐ Birth defects
☐ Hypertension	☐ Arthritis	☐ Tuberculosis
☐ Cancer	☐ Allergies	☐ Asthma
☐ Mental illness	☐ Osteoporosis	☐ Other significant: _____

Prenatal History

Mother's age at childbirth: _____

Mother's health during pregnancy:

☐ Bleeding	☐ Diabetes	☐ Cigarettes, alcohol, drug consumption
☐ Illnesses	☐ Hypertension	☐ Physical or emotional trauma
☐ Medications	☐ Nausea	☐ Thyroid problems

Birth History

Term: ☐ Full ☐ Premature ☐ Late Weight at birth: _____

Length of labor: _____ Complications: _____

Did your child have any of the following problems shortly after birth?

☐ Rashes	☐ Birth defects	☐ Blue baby
☐ Jaundice	☐ Seizures	☐ Cerebral palsy
☐ Colic	☐ Fever	☐ Birth injuries

☐ Other: _____

Current Symptoms

☐ Hives	☐ Allergies	☐ Frequent colds	☐ Dizzy spells
☐ Acne	☐ Vomiting	☐ Nose bleeds	☐ Hair loss
☐ Eczema	☐ No appetite	☐ Wheezing	☐ Flat feet
☐ Jaundice	☐ Stomach aches	☐ Asthma	☐ Bleeding gums
☐ Chronic rash	☐ Constipation	☐ Cough	☐ Anemia
☐ Cries easily	☐ Diarrhea	☐ Easy bruising	☐ Heart murmur
☐ Anxiety	☐ Burning urine	☐ Excessive fatigue	☐ Night sweats
☐ Nightmares	☐ Frequent urine	☐ High fevers	☐ Joint pain

Typical Food Intake:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Food intolerances: _____

Breast fed: How long: _____ Formula: Type (milk, soy)? _____

Age began solids: _____ Which foods: _____

List Vitamins, Minerals, Herbs, Homeopathic remedies presently taking, with dosage:

_____ _____

_____ _____

_____ _____

Please email to thenaturalpath@protonmail.com