SONG OF NATURAL MEDICINE
Dr. Crystal Song, NMD

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Pediatric Intake Form

Today's Date_____

Child's Name _____Parent/Guardian Name(s)_____

Age_____ Date of Birth_____Gender: Male ( ) Female ( )

HEALTH CONCERNS: (in order of importance)

1._____

2. _____

3. _____

MEDICAL HISTORY (please check all that apply to your child):

( ) Allergies (food, medication, environmental) _____

( ) Surgery For what?_____ When?_____

( ) Hospitalization For what?_____ When?_____

( )Trauma (i.e. accidents, falls, fractured bones, sprains, etc) Explain_____

Please mark either current (C) or past (P) to all that apply:

Conjunctivitis/Eye Infections ( )	Eczema/Hives/Rashes ( )	Anemia ( )	Yeast Infection/Thrush ( )
Chicken Pox ( )	Measles ( )	Mumps ( )	Rubella ( )
Mononucleosis ( )	Ear Infections ( )	Sinusitis ( )	Chronic Runny Nose ( )
Frequent Colds ( )	Asthma ( )	Pneumonia ( )	Allergies/Hay Fever ( )
Strep Throat/Tonsillitis ( )	Chronic Sore Throats ( )	Constipation ( )	Colic/Gas/Cramping ( )
Frequent Diarrhea ( )	Gastric Reflux ( )	Headaches ( )	Seizures ( )
Bed Wetting ( )	Heart Problems ( )	Depression ( )	Anxiety ( )
ADD/ADHD ( )			

FAMILY HISTORY: (Please indicate which relative, if any, has had the following):

( )Allergies_____ ( )Diabetes_____

( )Asthma_____ ( )Kidney disease_____

( )Cancer_____ ( )Heart disease_____

( )Depression_____ ( )ADD/ADHD_____

( )Other mental illness_____ ( )Autoimmune disease_____

( )Don't know family medical history

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MEDICATIONS: (past and current, include supplements): _____

_____

DIET: Does your child have any food sensitivities/intolerances/dietary restrictions? _____

_____

IMMUNIZATION HISTORY: (please indicate those your child has received and any reactions):

( ) DTaP (diphtheria, tetanus, pertussis) ( ) Td, Tdap ( ) MMR (measles, mumps, rubella)

( ) Haemophilus Influenza B (Hib) ( ) Flu ( ) Pneumococcal (PCV, PPV)

( ) Inactivated Polio (IPV) ( ) Hepatitis A (HepA) ( ) Hepatitis B (HepB)

( ) Meningococcal ( ) Rotavirus ( ) Varicella (chicken pox)

( ) Human Papillomavirus (HPV)

PRENATAL HISTORY:

Were there any complications during the pregnancy (trauma, emotional stress, high blood pressure, diabetes, bleeding, toxemia, hospitalizations, medications taken)? Please explain_____

_____

How was the labor and delivery? Were there any interventions (i.e. forceps, vacuum, C- section)?_____

_____

Was your child born: Pre-term Term Post-Term

NEONTAL/INFANT HISTORY:

Child's weight at birth _____ Child's length at birth _____

How were your child's APGAR scores at birth, if known? _____

Was your child breastfed? _____If Yes, for how long? _____

If No, what formula was your child given? _____

Was your child healthy during the neonatal period? _____ If No, please explain _____

At what age was solid food introduced? _____

DEVELOPMENTAL HISTORY:

At what age did your child start to teeth? _____

At what age did your child start to stand? _____

At what age did your child start to walk? _____

At what age did your child start to talk? _____

At what age did your child start to grow hair? _____

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SOCIAL HISTORY:

Does your child attend daycare or school? Yes No If Yes, what grade/level are they in? _____

How is your child's social and academic performance (both in school and at home)? _____

_____

Is your child involved in any extra-curricular activities, sports, hobbies? Yes No Please explain:

_____

What does your child enjoy doing on their spare time? _____

Does your child get exercise? Yes No How often/What type? _____

How much sleep does your child get, on average? _____