

Name _____

Date _____

The Center
Dr. Jennifer Orłowski, ND
1 Hoffman Street, Suite B
Auburn, NY 13021
315-704.0319

Pediatric Initial Intake Form

List in Order of Importance what your child's problems are:

- 1.
- 2.
- 3.
- 4.
- 5.

| | Diagnosed Condition | Doctor who diagnosed |
|----|---------------------|----------------------|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |
| 5. | _____ | _____ |

Family history

| | Father | Mother | Siblings | Grandparents | Spouse | Children |
|---------------------|--------|--------|----------|--------------|--------|----------|
| Age if living | _____ | _____ | _____ | _____ | _____ | _____ |
| Age when died | _____ | _____ | _____ | _____ | _____ | _____ |
| Reason for death | _____ | _____ | _____ | _____ | _____ | _____ |
| Cancer (type) | Y N | Y N | Y N | Y N | Y N | Y N |
| High Blood Pressure | Y N | Y N | Y N | Y N | Y N | Y N |
| Heart Attack/stroke | Y N | Y N | Y N | Y N | Y N | Y N |
| Heart disease | Y N | Y N | Y N | Y N | Y N | Y N |
| Asthma/allergies | Y N | Y N | Y N | Y N | Y N | Y N |
| Mental illness | Y N | Y N | Y N | Y N | Y N | Y N |
| TB | Y N | Y N | Y N | Y N | Y N | Y N |
| Auto-immune disease | Y N | Y N | Y N | Y N | Y N | Y N |
| Diabetes Mellitus | Y N | Y N | Y N | Y N | Y N | Y N |
| Osteoporosis | Y N | Y N | Y N | Y N | Y N | Y N |

List All Surgeries and Hospitalizations—including date occurred:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Name _____

Date _____

Please Note When and Why You Had Each of The Following:

X-rays: _____

MRI/Cat Scans: _____

Ultrasounds: _____

Accidents: _____

Please List All Sensitivities/Allergies/Reactions

Drugs: _____

Foods: _____

Environment: _____

Did you have the following Disease (D), Get Immunized for it (I), or Neither (N):

Measles: D I N Diptheria: D I N

Mumps: D I N Tetanus: D I N

Rubella: D I N Whooping Cough: D I N

Chickenpox: D I N Hemophilus (Hib): D I N

German Measles: D I N Hepatitis B: D I N

Any vaccination reactions: _____

List Yes, No, or Past regarding use of the following:

Antacids: Y N P Steroids: Y N P

Analgesics: Y N P Laxatives: Y N P

Coffee: Y N P Cups per day if Yes/Past: _____

Soda Pop: Y N P Ounces per day if Yes/Past: _____

List all Prescription Medicines and Nutrient Supplement/Herbs Taking:

Name _____

Date _____

Review Of Systems:

Present Weight: _____

Present Height _____

REGARDING THE NEXT LONG SECTION: Please Circle **Y** if your child have the problem **NOW**, **N** if they **NEVER** had the problem, **P** if they had the problem in the **PAST**.

Skin:

Rash: Y N P
Hives: Y N P
Psoriasis/eczema: Y N P
Dry: Y N P
Cancer: Y N P

Color Change: Y N P
Lump: Y N P
Itchy: Y N P
Warts/moles: Y N P
Perspiration: Y N P

Head:

Headache: Y N P
Dandruff: Y N P
Oil/dry hair: Y N P

Migraine: Y N P
Head Injury: Y N P
Hair loss: Y N P

Eyes:

Dry/Watery: Y N P
Double vision: Y N P
Discharge: Y N P
Dark under eyelid: Y N P

Blurry vision: Y N P
Styes: Y N P
Itchy: Y N P

Nose:

Frequent colds: Y N P
Congestion: Y N P
Polyps: Y N P

Nosebleeds: Y N P
Post nasal drip: Y N P
Seasonal allergies: Y N P

Mouth/Throat:

Canker sores: Y N P
Sore throat: Y N P
Cavities: Y N P
Hoarseness: Y N P

Cold sores: Y N P
Gum disease: Y N P
Loss of taste: Y N P

Neck:

Stiffness: Y N P

Swollen glands: Y N P

Name _____

Date _____

Respiratory:

| | | | |
|------------------------------------|-------|--------------------|-------|
| Cough: | Y N P | TB: | Y N P |
| Shortness of breath with exertion: | Y N P | Bronchitis: | Y N P |
| Shortness of breath sitting: | Y N P | Pneumonia: | Y N P |
| Shortness of breath lying down: | Y N P | Asthma: | Y N P |
| Wheezing: | Y N P | Painful breathing: | Y N P |

Cardiovascular:

| | | | |
|----------------------|-------|------------------|-------|
| High blood pressure: | Y N P | Rheumatic Fever: | Y N P |
| Low blood pressure: | Y N P | Murmurs: | Y N P |
| Arrhythmias: | Y N P | Palpitations: | Y N P |
| Edema: | Y N P | Chest pain: | Y N P |

Gastrointestinal:

| | | | |
|-----------------------|-------|---------------------------|-------|
| Heartburn: | Y N P | Bowel movement frequency: | _____ |
| Indigestion: | Y N P | Recent change in BM: | Y N P |
| Bloating: | Y N P | Diarrhea or constipation: | Y N P |
| Nausea: | Y N P | Vomiting: | Y N P |
| Gall bladder disease: | Y N P | | |
| Change in Appetite: | Y N P | | |

General

Sleep patterns ? _____

Breast Fed or Bottle Fed ? _____

If breast fed how long? _____

If formula fed what kind? _____

Age food was introduced _____

Where there any allergies to foods ? _____

If so, what foods did the child react to? _____

Does the child have a history of chronic ear infections? _____

If so, how many have they had since birth ? _____

Does the child have a history of antibiotic use? _____

If so, how many times have they been given? _____

Vaginal or C section Birth? _____

Did your child have colic? _____