

TLC-Pediatric Intake Form

The Luna Center for Natural Health

Thank you for completing this form. Your, time, thoughtfulness and honesty in completing this intake form will greatly assist me in your healthcare. All information is confidential.

How did you hear about us? _____

Allergies

Allergies	Type	Severity	Reactions

Medications

Medication Name	Intake Details

Supplements

Supplement Name	Intake Details

Mother

Name _____

Mother's phone no: _____

Mother's email: _____

Father

Name _____

Father's phone no: _____

Father's email: _____

Siblings

Names, Gender and Ages

Are these children healthy?

Yes No

If not, please explain briefly:

Child

Please list the top 3 reasons for your child's naturopathic visit and describe briefly.

What other health conditions or concerns does your child have that are not listed above?

Any complications during the pregnancy of this child?

Yes No

If yes, please describe briefly:

Any complications during the birth of this child?

Yes No

If yes, please describe briefly:

Did you breast-feed your child and if so, for how long?

Does your child have any developmental problems?

Yes No

If yes, please describe:

If your child has received vaccinations, please list:

Any adverse reactions to any vaccinations?

Yes No

If yes, please explain:

If the child has a primary care provider, please list the name and if you are planning on adjunctive or transfer of care:

When was your child's last physical exam?

Has your child received any diagnostic workups eg. labs, imaging?

Yes No

If yes, please explain and when:

Diet Information:

This is a brief summary of what the child generally eats and drinks for breakfast, lunch, dinner and snacks. It is not meant to be detailed. You can think back to the last few days or put down foods eaten on a regular basis.

Breakfast:

Lunch:

Dinner:

Snacks:

Family History

Check family members that apply

Allergies

Child Brothers Sisters
 Father Mother Grandparent
 None

Asthma

Child Brothers Sisters
 Father Mother Grandparent
 None

Birth Abnormalities

Child Brothers Sisters
 Father Mother Grandparent
 None

- | | | | |
|-----------------------------------|---------------------------------|-----------------------------------|--------------------------------------|
| Bronchitis | <input type="checkbox"/> Child | <input type="checkbox"/> Brothers | <input type="checkbox"/> Sisters |
| | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Grandparent |
| | <input type="checkbox"/> None | | |
| Diabetes | <input type="checkbox"/> Child | <input type="checkbox"/> Brothers | <input type="checkbox"/> Sisters |
| | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Grandparent |
| | <input type="checkbox"/> None | | |
| Ear Aches/Frequent ear infections | <input type="checkbox"/> Child | <input type="checkbox"/> Brothers | <input type="checkbox"/> Sisters |
| | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Grandparent |
| | <input type="checkbox"/> None | | |
| Epilepsy, Seizures | <input type="checkbox"/> Child | <input type="checkbox"/> Brothers | <input type="checkbox"/> Sisters |
| | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Grandparent |
| | <input type="checkbox"/> None | | |
| Gastrointestinal Disturbances | <input type="checkbox"/> Child | <input type="checkbox"/> Brothers | <input type="checkbox"/> Sisters |
| | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Grandparent |
| | <input type="checkbox"/> None | | |
| Hepatitis | <input type="checkbox"/> Child | <input type="checkbox"/> Brothers | <input type="checkbox"/> Sisters |
| | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Grandparent |
| | <input type="checkbox"/> None | | |

Child's Medical History

- Past or present illnesses, please check all that apply:
- | | | |
|---|---|---|
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> measles | <input type="checkbox"/> mumps |
| <input type="checkbox"/> rubella | <input type="checkbox"/> pneumonia | <input type="checkbox"/> scarlet fever |
| <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> seizures | <input type="checkbox"/> facial tics |
| <input type="checkbox"/> warts | <input type="checkbox"/> headaches | <input type="checkbox"/> hayfever |
| <input type="checkbox"/> eczema | <input type="checkbox"/> asthma | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> back pain | <input type="checkbox"/> muscle pain | <input type="checkbox"/> ear infections |
| <input type="checkbox"/> strep throat | <input type="checkbox"/> head injury | <input type="checkbox"/> broken bones |
| <input type="checkbox"/> problems with chewing/swallowing | <input type="checkbox"/> problems with vision | <input type="checkbox"/> problems with hearing |
| <input type="checkbox"/> problems with speech | <input type="checkbox"/> dyslexia | <input type="checkbox"/> problems with motor coordination |
| <input type="checkbox"/> bed wetting | | |

How often has your child been ill in the last year?

How often has your child taken antibiotics in the last year?

Has your child had any car accidents, falls, surgeries, or major illnesses not listed above?

Is your child being treated by a
psychiatrist, psychologist or counselor?

Yes No

If yes, please describe briefly:

Does your child sleep well?

Yes No

If not, please explain:

How is your child doing at school?

Does your child play well with other
children?

Yes No

If no, please describe briefly:

Any additional information which you feel is
important can be provided here