Northwestern Medicine®

Osher Center for Integrative Medicine

Pediatric Intake Form

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Current Pediatrician:

_____

How did you hear about us? _____

What are your goals for this visit? Where would you like to see improvement in your child's health?

_____

_____

_____

Child's Current Medical Problems (e.g. developmental delay, ADHD, stress, anxiety):

1.	4.	7.
2.	5.	8.
3.	6.	9.

Past Medical/Surgical History Please list any past surgeries, illnesses, hospitalizations, NICU stay (include year or date and location if known):

1.	4.	7.
2.	5.	8.
3.	6.	9.

Medications and Dietary Supplements Please list all prescribed and over-the-counter medications, supplements, vitamins or herbal products you child uses on a regular basis:

Medicine or Supplement including Dose	Currently taking? If discontinued, when?
1.	
2.	
3.	
4.	
5.	
6.	

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Allergies Please list any drugs that your child has an allergy to? What was the reaction?

_____

Please list any allergies (food or environmental) your child may have an allergy to:

_____ _____

_____ _____

Family History Have your close relatives had the following?

	Father	Mother	Brother	Sister	PGF	PGM	MGF	MGM	Other
Alive (A) or Deceased (D)									
Heart attack or congenital heart disease									
Stroke									
Eczema									
Obesity									
Diabetes									
Thyroid disease									
Cancer									
Food allergies									
Celiac disease									
Developmental Delay									
Psychiatric illness									
Autism									
ADHD									
Asthma									
Sensory Integration Disorder									
Substance Abuse									
Autoimmune illness (e.g. psoriasis, rheumatoid arthritis, Celiac disease, lupus)									
Other									

PGF=paternal grandfather PGM=paternal grandmother MGF=maternal grandfather MGM= maternal grandmother

Please describe the birth and development history?

Prenatal issues? _____

Born Full term? _____

NICU history? _____

Reached developmental milestones on time (crawl/walk/talk)?

_____

Have you had concern over your child's learning abilities or language?

_____

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Preventive Health Please provide the most recent date and documentation when possible:

Vaccines	Date:	**Vaccines**	Date:
2 mo vaccines		Influenza	
4 mo vaccines		Gardasil	
6 mo vaccines		5 yr vaccines	
12 mo vaccines		CBC/ Lead (result?)	
Eye Exam		Hemoglobin (result?)	

Healthcare Team Please list all health providers that you see. Please include physicians specialists, mental health professionals and any integrative providers (e.g. chiropractor, acupuncturist, naturopath, massage therapist):

NAME	**SPECIALTY**	**CONDITION BEING TREATED**

Exercise, Sleep, and Screens

Does your child exercise? Enrolled in sports?

_____

How many hours of sleep does your child get per night ____ Do you have sleep concerns? Y/N

How much screen time does your child get per day? _____

Please list everything your child ate in the last 24 hours **OR** in a typical day:

Breakfast:
Lunch:
Dinner:
Snacks:

Is your child a picky eater? _____

If yes, please describe: _____

_____

Who prepares your meals? _____

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Education:

What grade is your child in? _____

Have teachers ever expressed concerns about your child?

_____

Has your child ever had an IEP or a 504 plan? _____

Relationships

What is your current marital status?

_____

What is your living arrangement? _____

Do you have other children (age, sex, number):

_____

Pain

Is your child in pain? _____

Where? _____

For how long? _____

What have you tried to relieve the pain? _____

Physical Environment

Do you have specific health concerns about your current home or work environment (Quality of air, water, toxin exposure etc.)?

_____

Support

Does your child have strong relationships?

_____

Who is his/her best friend?

_____

Spirituality

What things or activities bring your child your joy and meaning? What is your child good at?

_____

Do you have a religious/racial/cultural heritage that is important to your family? Where do you find hope?

_____

What makes your child feel connected to the larger world? Describe any spiritual or religious practices if any (e.g. meditation, prayer, time in nature, worship attendance).

_____

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Mind-Body Connection

Rate the amount of stress in your child's life:

□ None □ A Little Bit □ Moderate □ Quite a Lot □ Extreme

How well does your child manage stress?

□ Not at All □ A Little Bit □ Moderate □ Quite well □ Excellent

What are the main sources of stress in your child's life?

_____

What are your child's methods of coping with the stress?

_____

Please list any modalities you have tried with your child? Hypnosis? Meditation? Guided Imagery? Biofeedback? Yoga?

_____

Trauma History? (Y=Yes, N= no)

Has your child been exposed to prolonged periods of stressful situations at home?
Divorce/marital discord?
Sick family member?
Incarceration of a family member?
Exposure to violence?
Mental health issues with a family member?
Substance abuse by a family member?
Has your child ever been neglected?
Has your child experienced bullying?
Has your child experienced prolonged economic hardship?

What do you hope for your child's future?

_____

Is there anything else that would be helpful for us to know about your child?

_____

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Review of Symptoms

Please circle if your child has had any of the following symptoms **within the past 3 months**

GENERAL
Fever
Sweats at night
Temperature intolerance
Excessive thirst
Fatigue
Sleep difficulties
Unplanned weight change
Delayed growth
Failure to thrive

EYES
Pain
Redness
Vision change

EAR, NOSE, THROAT
Hearing loss
Ringing in ears
Dizziness or vertigo
Bleeding gums
Nosebleeds

CARDIOVASCULAR
Chest pain
Irregular heart beat (palpitations)
Leg swelling or edema

PULMONARY
Wheezing or shortness of breath
Chronic cough
Coughing blood

HEMATOPOIETIC
Swollen lymph glands
Excessive bleeding

PSYCHOLOGICAL
Anxiety
Depression
Memory issues
Mood swings
Hyperactivity
Attention difficulties

GASTROINTESTINAL
Diarrhea
Constipation
Indigestion/heartburn
Abdominal pain
Nausea
Blood in stool
Abdominal bloating

GENITOURINARY
Pain or burning on urination
Frequent urination
Waking to urinate more than once at night
Difficulty emptying bladder
Urinary incontinence
Pain with intercourse

ADOLESCENT GIRLS:
Heavy vaginal discharge
Heavy menstrual bleeding
Painful menstrual periods
Irregular menstrual bleeding

BREAST
Breast Pain
Masses and or Lumps
Nipple discharge
Skin changes

MUSCULOSKELETAL
Generalized or all-over pain
Joint pain
Stiffness
Joint swelling or redness
Back or neck pain

SKIN
Rash

NEUROLOGICAL
Abnormal gait (trouble walking) or falls
Headache (severe and/or frequent)
Seizure