GW Center for Integrative Medicine
908 New Hampshire Avenue, Suite 200, Washington, DC 20037
Tel 202-833-5055, Fax 202-833-5755

Pediatric Health Intake

Date (MM/DD/YY) _____/_____/_____

PERSONAL INFORMATION

Child's Full Name _____ Age _____ Sex ☐ M ☐ F

Address _____ Date of Birth (M/D/Y) ____/____/___

_____ Phone (___)_____

Mother / Guardian
Full Name _____
Address _____
_____
Phone H (___)_____ W (___)_____
Occupation _____

Father / Guardian
Full Name _____
Address _____
_____
Phone H (___)_____ W (___)_____
Occupation _____

Marital Status (*check* ✓)	single	married	separated	divorced	widowed	common-law	other
mother							
father							

Contacts (if different from above) (*in order of preference*)

Name _____ Name _____
Address _____ Address _____
_____ _____
Phone H (___)_____ W (___)_____ Phone H (___)_____ W (___)_____
Relationship to Child _____ Relationship to Child _____

Name of person filling out this form _____ Relationship to Child _____

Other Health Care Providers

Name			
Address Phone #	( )	( )	( )
Specialty			

Referred by _____

CHIEF HEALTH CONCERNS

	Health Concern (*please list in order of importance*)	When did it start?	What makes it better?	What makes it worse?
1				
2				
3				

MEDICAL HISTORY

Child's general state of health now (*circle*): poor fair good excellent unknown
Child's general state of health in first year *(circle)*: poor fair good excellent unknown

Medication	Age	Reason for Administration	Adverse Reaction
Current Medications (prescription, non-prescription, vitamins/minerals, supplements, herbs, homeopathics, other)			
Past Medications (prescription only)			

How many times treated with antibiotics? _____

Allergies / Sensitivities (medications, foods, environment)

Childhood Illnesses (N = never had, M = mild, A = average, S = severe) (check ✓)

Illness	N	M	A	S	Illness	N	M	A	S	Illness	N	M	A	S
measles					rheumatic fever					mononucleosis				
rubella (German measles)					scarlet fever					tonsillitis				
mumps					polio					strep throat				
pertussus (whooping cough)					diphtheria					ear infection				
chicken pox					impetigo					colds				
roseola					pneumonia					other _____				

Serious Conditions, Illnesses, Injuries, Surgeries, Hospitalizations *(please list)* Date (MM/DD/YY)

_____ _____/_____/_____
_____ _____/_____/_____
_____ _____/_____/_____

Immunization *(check ✓)*	Age	Adverse Reaction	***Immunization*** *(check ✓)*	Age	Adverse Reaction
measles			haemophilus influenza B		
mumps rubella (German measles)			hepatitis B hepatitis A		
diptheria			"flu"		
pertussis (whooping cough)			pneumococcal		
tetanus			other _____		
polio					

Screening Test *(check ✓)*	Results	***Screening Test*** *(check ✓)*	Results	***Screening Test*** *(check ✓)*	Results
blood		urinalysis		sickle-cell	
vision		hematocrits		blood lead	
hearing		phenylketonuria		cholesterol	
tuberculin		galactosemia		other _____	

FAMILY HISTORY

Do either parents have a chronic illness? ☐ yes --> _____ ☐ no
Indicate if a close relative (parent, sibling) has had any of the following:

Condition	***Who?***	***Condition***	***Who?***	***Condition***	***Who?***	***Condition***	***Who?***
kidney disease		stroke		arthritis		sickle cell disease	
heart disease		diabetes		anemia		mental illness	
high cholesterol		tuberculosis		allergies		epilepsy/convulsions	
high blood pressure		headaches		asthma		cancer	
mental retardation		insanity		syphilis		other _____	
alcohol/drug addiction		birth defects		obesity			

BIRTH HISTORY

PRENATAL (before birth) *(circle all that apply)*

Health of parents at conception Mother: poor fair good excellent unknown
Father: poor fair good excellent unknown
Age of mother at conception _____
Health of mother during pregnancy: poor fair good excellent unknown
Mother's diet during pregnancy: poor fair good excellent unknown
Supplements taken during pregnancy _____
_____
Did mother receive prenatal medical care? Y N unknown
Illnesses related to or complicated by pregnancy: high blood pressure bleeding nausea diabetes
thyroid problems physical/emotional trauma
Mother's use during pregnancy: prescription meds non-prescription meds
recreational drugs supplements alcohol tobacco
Term length: full premature _____ wks late _____ wks
Emotional state & attitude toward fetus: negative positive

Comments _____

NATAL (at birth) *(circle all that apply)*

Degree of difficulty of labour & delivery: not difficult somewhat difficult very difficult
Length of labour _____ Weight at birth _____
Nature of delivery: vaginal c-section induced analgesia forceps
Complications encountered _____

Comments _____

NEONATAL (first 4 weeks after birth) *(circle all that apply)*

Health condition immediately after birth: weak cry intense cry feeble activity vigorous activity
APGAR score _____
Problems encountered: feeding problems respiratory distress cyanosis
jaundice anemia convulsions seizures
infection hemorrhage snuffles skin rashes
skin shedding paralysis birth injuries birth defects
colic fever other _____
Mother's health postpartum: poor fair good excellent unknown

Comments _____

DIET

INFANCY *(circle all that apply)*

Breast feeding: length of time _____ difficulties
Alternate feeding: formula milk soy other _____
difficulties (regurgitation, colic, diarrhea)
First liquid (aside from water) introduced after weaning: _____
Supplements (eg. vitamins, minerals) given *(list type & amount)*: _____
Iron supplements given *(list amount):* _____

Foods introduced before 6 months:	Food	Month Introduced	Infant's Response
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Food introduced between and 6 to 12 months:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Comments _____

CHILDHOOD *(circle all that apply)*

Eating habits: likes _____ dislikes _____
Appetite: poor fair good excellent unknown
Ever had colic? yes no mild moderate severe
Food allergies or intolerances: *(list)* _____
_____
Dietary restrictions: none religious vegetarian vegan other _____
Describe a typical day's diet: breakfast _____
lunch _____
dinner _____
snacks _____
beverages (and total quantity) _____

Comments _____

GROWTH & DEVELOPMENT

Physical Growth

	At birth	1 year	2 years	5 years	10 years
Weight					
Height					

Developmental Milestones

Age at which child began:
holding up head _____ rolling over _____ sitting alone _____ crawling _____
walking alone _____ first words _____ tied own shoes _____ dressed without help _____

Comments _____

Social Development *(circle all that apply)*

Sleep patterns: nightmares terrors sleep-walking other _____
Toileting: enuresis encopresis Age when bladder & bowel control attained _____
Speech: hesitation stuttering baby talk lisping other _____
Habits: bed rocking head banging ticks thumb sucking nail biting
Child's reaction to Discipline: success failure
negativism temper tantrums withdrawl aggressive behaviour

Schooling - child's experience with Day Care: encouraging disappointing school's concern _____
Nursery: encouraging disappointing school's concern _____
Kindergarten: encouraging disappointing school's concern _____
Home School: encouraging disappointing your concern _____
Personality: not independent somewhat independent very independent
Good relationships with: parents siblings peers
Comments _____

ENVIRONMENT

Emotional climate at home: _____
Child's typical day: _____
_____
Does child exercise reguarly? yes no how much? _____ how often? _____
Amount of television child watches is _____ hrs per day per week
Child's favourite activities: _____
How often child reads or how often someone reads to child *(circle)*: daily weekly other _____
Type of heating in child's home: _____
Does anyone in child's home smoke? yes no
Are there any pets in home? yes no
Toxins or other hazards child is regularly exposed to: _____

Is there anything that you feel is important that has not been covered? _____
_____
_____

REVIEW OF SYSTEMS

(For each condition listed below, please mark ALL the boxes that apply to you - CURRENTLY have now, had in the PAST, NEVER had - and make any comments/explanations needed that would make the given information more clear.)

CONDITION	*CURRENT*	*PAST*	*NEVER*	*CONDITION*	*CURRENT*	*PAST*	*NEVER*
GENERAL							
fever	□	□	□	night sweats	□	□	□
chills	□	□	□	frequent infections	□	□	□
other _____	□	□	□				

Overall State of Health □ poor □ fair □ good □ great Comments _____
Ability to Carry Out Daily Activities □ poor □ fair □ good □ great Comments _____
Exercise Tolerance □ poor □ fair □ good □ great Comments _____
COMMENTS _____

INTEGUMENT (SKIN)							
itching	□	□	□	tiny red spots (small blood loss)	□	□	□
pigment (or other colour changes)	□	□	□	excessive dryness	□	□	□
acne	□	□	□	disorders/deformaties of nails	□	□	□
eruptions	□	□	□	hair growth/loss	□	□	□
rashes —> location_____	□	□	□	hair colour change	□	□	□
tendency for bruising	□	□	□	other _____	□	□	□

General Texture _____
COMMENTS _____

HEAD							
headaches	□	□	□	injury —>_____	□	□	□
dizziness	□	□	□	lice	□	□	□
other _____	□	□	□				

COMMENTS _____

CONDITION	CURRENT	PAST	NEVER	CONDITION	CURRENT	PAST	NEVER
EYES							
visual problems	□	□	□	bumping into objects	□	□	□
clumsiness	□	□	□	sitting very close to television	□	□	□
holding book close to face	□	□	□	writing with head near desk	□	□	□
squinting	□	□	□	rubbing eyes	□	□	□
cross-eye	□	□	□	swelling of lids	□	□	□
eye infections	□	□	□	excessive tearing	□	□	□
use of eye glasses or contacts	□	□	□	other _____	□	□	□

Date of Last Optic Examination (M/D/Y) ____/____/____
COMMENTS _____

NOSE							
nosebleeds	□	□	□	nasal obstruction (breathing)	□	□	□
constant/freq. running/stuffiness	□	□	□	alteration/loss of sense of smell	□	□	□
other _____	□	□	□				

COMMENTS _____

EARS							
earaches	□	□	□	loud speech	□	□	□
hearing loss	□	□	□	inattentive behaviour	□	□	□
need to repeat requests	□	□	□	other _____	□	□	□

Results of Previous Auditory Testing _____
COMMENTS _____

MOUTH							
mouth-breathing	□	□	□	toothaches	□	□	□
gum bleeding	□	□	□	teething difficulty	□	□	□
other _____	□	□	□				

Tooth Brushing frequency_____ flouride use □ yes □ no
Date of Last Dentist Visit (M/D/Y) ____/____/____ Response to Dentist _____
COMMENTS _____

THROAT							
sore throats	□	□	□	choking	□	□	□
swallowing difficulty	□	□	□	hoarseness	□	□	□
other voice irregularities	□	□	□	other _____	□	□	□

COMMENTS _____

NECK							
pain	□	□	□	difficulty in holding head straight	□	□	□
limitation of movement	□	□	□	thyroid enlargement	□	□	□
stiffness	□	□	□	enlarged nodes/masses	□	□	□
other _____	□	□	□				

COMMENTS _____

CHEST							
breast enlargement	□	□	□	breast masses	□	□	□
breast discharge	□	□	□	enlarged nodes near armpit	□	□	□
other _____	□	□	□				

COMMENTS _____

RESPIRATORY							
chronic coughs	□	□	□	frequent colds —> # per yr.____	□	□	□
wheezing	□	□	□	shortness of breath (rest/exertion)	□	□	□
breathing difficulties	□	□	□	sputum production	□	□	□
infections	□	□	□	pneumonia	□	□	□
tuberculosis	□	□	□	other _____	□	□	□

Date of Last Chest X-Ray Examination (M/D/Y/) ____/____/____
COMMENTS _____

CONDITION	*CURRENT*	*PAST*	*NEVER*	*CONDITION*	*CURRENT*	*PAST*	*NEVER*
CARDIOVASCULAR							
cyanosis or fatigue on exertion	□	□	□	heart murmur	□	□	□
anemia	□	□	□	rheumatic fever	□	□	□
blood transfusion	□	□	□	other _____	□	□	□
Date of Last Blood Count (M/D/Y) ____/____/____				Blood Type □ A □ B □ AB □ O			
COMMENTS _____							
GASTROINTESTINAL							
nausea (not associated w/ eating)	□	□	□	belching	□	□	□
vomitting (not associated w/ eating)	□	□	□	flatulence	□	□	□
jaundice (yellowing skin or sclera)	□	□	□	blood in stools	□	□	□
stool colour change	□	□	□	diarrhea	□	□	□
constipation	□	□	□	other _____	□	□	□
COMMENTS _____							
GENITO-URINARY							
pain on urination	□	□	□	hesitancy	□	□	□
urgency	□	□	□	blood in urine (hematuria)	□	□	□
excessive secretion of urine	□	□	□	excessive urination at night	□	□	□
unpleasant odour to urine	□	□	□	force of stream	□	□	□
discharge	□	□	□	change in size of scrotum	□	□	□
other _____	□	□	□	urination frequency (# per day) _____			
Date of Last Urinalysis (M/D/Y) ____/____/____							
COMMENTS _____							
GYNECOLOGIC							
menstrual problems	□	□	□	irregular cycles	□	□	□
painful menses	□	□	□	PMS	□	□	□
excessive flow	□	□	□	bleeding b/w periods	□	□	□
diminished flow	□	□	□	vaginal discharge	□	□	□
vaginal itching	□	□	□	other _____	□	□	□
Age of Menarche (menses began)		_____		Avg. # of Days Period Lasts		_____	
Length of Menstrual Cycle		_____		Date of Last Menstrual Period		_____	
COMMENTS _____							
MUSCULOSKELETAL							
weakness	□	□	□	clumsiness	□	□	□
lack of coordination	□	□	□	unusual movements	□	□	□
back or joint stiffness	□	□	□	muscle pains or cramps	□	□	□
abnormal gait	□	□	□	deformity (muscles/bones)	□	□	□
fractures	□	□	□	serious sprains	□	□	□
other _____	□	□	□	Activity Level □ poor □ fair □ good □ great			
COMMENTS _____							
NEUROLOGIC							
seizures	□	□	□	tremors	□	□	□
dizziness	□	□	□	loss of memory	□	□	□
fears	□	□	□	nightmares	□	□	□
speech problems	□	□	□	unusual habits	□	□	□
other _____	□	□	□				
COMMENTS _____							
ENDOCRINE							
intolerance to weather changes	□	□	□	excessive thirst	□	□	□
excessive urination	□	□	□	excessive sweating	□	□	□
salty taste to skin	□	□	□	signs of early puberty	□	□	□
other _____	□	□	□				
COMMENTS _____							