Pediatric and Adolescent Initial Intake Form

To be completed by parent or guardian

Name_____Date_____SSN_____

Address_____City_____State_____Zip_____

Phone (H) _____ (W)_____Email_____

Date of Birth _____Age_____Sex_____School_____

Emergency Contact_____Phone_____

How did you hear about Dr. Laura Sleggs? _____

Family Doctor (name)_____(address)_____

Is this child under the care of a specialist (name, number)? _____

Is this child under the care of an alternative healthcare provider (ie acupuncturist, chiropractor, massage therapist)?_____

What is your child's primary reason for attending this clinic? Please list the first time you noticed the condition and describe any factors that you suspect may have a role in its onset and course.

1. _____

_____

When did it start_____Has this condition been diagnosed? Yes no _____

Are you receiving any kind of treatment for this condition? Please describe:

_____

Have any of these brought your relief? _____

Please list any other health concerns:

2. _____

3. _____

4. _____

5. _____

Please list past health problems and dates:

1._____

2._____

3._____

Which childhood Illnesses has this child had? (please check and indicate child's age at time of infection):

☐ Measles _____
☐ Rubella _____
☐ Mumps _____
☐ Whooping cough____
☐ Chicken pox _____
☐ Pneumonia _____
☐ Scarlet Fever_____
☐ Polio _____
☐ Tonsillitis _____
☐ Ear infections (how many?) _____
☐Frequent colds_____
☐Mononucleosis_____
☐Strep throat_____ (how many times?)_____
☐Other_____

Family History Indicate if anyone in your family has or has had any of the following conditions.

Was this child adopted? Y N

	Father	Mother	Brothers	Sisters	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if living)								
Health (G=good,P=poor)								
Anemia								
Asthma, Hayfever, Hives								
Cancer								
Cystic Fibrosis								
Diabetes								
Epilepsy								
Rheumatoid Arthritis								
Heart Disease								
High Blood Pressure								
Kidney Disease								
Mental Illness								
Alcoholism								
Stroke								
Tuberculosis								
Other								
Age (at death)								
Cause of death								

Does your child have any allergies (food, environmental, drug, chemical)? Please describe any adverse reactions he or she has had:

_____

_____

Do you have any pets? _____

Please check the vaccinations your child has received. Please check or attach photocopy of vaccination record. If you don't know if you've had one, place a question mark beside it.

	When?		When?
Diphtheria, Pertussis, Tetanus		Measles, Mumps, Rubella	
Polio		Chicken pox	
Haemophilus influenza B		Prevnar	
Influenza (flu shot)		Other	

Any adverse reaction to vaccinations (redness at site, crying, screaming, fever, limp?)

_____

List all family members the child lives with:_____

Prenatal History

Parents heath at conception (G=good, P=poor): Mother:_____ Father:_____

Was this child conceived naturally? Y N Any fertility interventions? Y N _____

Any illness or difficulties during pregnancy? (circle) Nausea Diabetes Hypertension

Thyroid problems Emotional trauma Vomiting Bleeding Illness Physical trauma
Other: _____

List any drugs, alcohol, cigarette smoking or medications taken during pregnancy:

_____

List any vitamins or other supplements taken during pregnancy:

_____

_____

Mother's age at birth:_____ Father's age at conception:_____

Mother's pregnancy weight gain: _____lbs

Birth History

How long was the pregnancy? (circle) full term late premature # of weeks:_____

Was the labor spontaneous or induced? (circle)
Duration of labor: _____hrs

Was delivery by C-section or vaginal birth? (circle) Hospital or home birth? (circle)

Birth weight?_____ Birth length:_____ APGAR Scores: 1 min_____ 5 min_____

Interventions: (circle) epidural episiotomy forceps suction

Difficulties or Complications:_____

Neonatal History

Any difficulties or complications soon after birth?

- ☐ Jaundice
- ☐ Respiratory distress
- ☐ Convulsions
- ☐ Birth defects
- ☐ Rashes
- ☐ Poor feeding
- ☐ Anemia
- ☐ Infections
- ☐ Colic
- ☐ Other

Age began: sitting _____ crawling _____ walking _____ talking _____ 1st tooth _____

Any problems with the child's teeth? _____

How would you characterize your child's development? (circle)
Physical: slow average fast
Mental: slow average fast

Has child started puberty? Y N if yes, when?_____

Nutrition

Infant feeding: Breast fed – how long? _____
Formula fed – describe type:_____
When started:_____
Age of introduction of solids: _____

What were the first foods introduced? _____

Childhood eating habits:_____

Are there any food groups excluded from your child's diet? Y N
Why: _____

General Information Height_____ Weight_____

Has your child ever experienced any trauma? (circle)Fractures Accidents Emotional
Describe: _____

How would you describe your child's daycare or school experience (if appropriate) in terms of performance, enjoyment and socialization? _____
_____

Has your child had any specialized screening tests?
Explain:_____

What are your child's interests?_____

How many days/week does your child participate in out-of-school programs?_____

Would you characterize the home environment as: (circle)
Very stable Stable Stressful Very stressful

How many hours per day does your child use: TV_____ computer _____ video games _____

Past Medical History List all surgeries, hospitalizations or major injuries your child has had.

Procedure/reason/injury	Year	Outcome

Please list any medications or supplements that your child is currently taking:

Pharmaceutical drugs or supplements (include brand)	How much do you take per day?	Why are you taking this medication?

How many times has your child taken antibiotics? _____

Toxin Exposure

Have you ever been exposed to mold, solvents, lead paint, heavy metals, fumes or other toxic substances at home (hobbies, renovations), at work or while traveling?	Y	N
Have you ever experienced health problems after putting down new carpeting, painting your home, doing renovations or having your lawn sprayed with herbicide?	Y	N
Are you particularly sensitive to perfume, gasoline or other vapors?	Y	N
Do you have any mercury dental fillings?	Y	N
Do you have any surgical implants (cosmetic, medical)?	Y	N
Do you live near any of the following? Industry Power lines Highway Dump Airport	Y	N

How old is your home? _____ How long have you lived there? _____

Has your child traveled outside of the United States? Where and when? _____

Is the child exposed to tobacco smoke?_____

Review of Symptoms (please check current symptoms, use P for past):

Acne		Slow wound healing	
Eczema, rashes		Sore throat	
Hives, itching		Coughing	
Changes in skin odor		Lumps, swollen glands	
Changes in hair/nails		Discharges (eyes, ears, nose, other sites)	
Cradle cap		High fevers	
Recent weight change		Anemia	
Weakness, fatigue		Vision problems	
Muscle or joint pain/stiffness		Hearing problems	
Change in posture/gait		Heat and or cold intolerance	
Trouble chewing swallowing		Excessive sweating	
Change in appetite		Night sweats	
Excessive/diminished thirst		Cries easily, weepy	
Excessive/diminished hunger		Nervous	
Diarrhea		Irritable	
Constipation		Sudden changes in mood	
Frequent vomiting		Strong fears or aversions	
Stomach/abdominal aches		Nightmares, night terrors	
Excessive belching		Memory problems	
Excessive gas		Wheezing, difficulty breathing	
# of bowel movements/day		Body/breath odor	
Burning urination		Motion sickness	
Bed wetting		Joint pain	
Frequent urination		Easy bruising	
Blood in urine		Nose bleeds	
Age at potty training		Is child fully potty trained?	

Sleep

Sleep patterns during the first year:_____

Usual time child goes to bed and awakens:_____

Any napping during the day:_____

Difficulties in falling asleep or staying awake:_____

Sensitivities

Is your child particularly sensitive to any of the following? (circle)

Claustrophobia cold height drafts heat music smells sunlight wind wool

Briefly describe your child's personality including both positive and negative characteristics:

_____

Is there anything else your would like to add that may be relevant to your child's case?_____

_____

Thank you for completing this form as accurately and completely as possible. It will greatly help me to obtain a more complete understating of your child.

Informed Consent and Agreement

I voluntarily consent to the procedures and treatments by Dr. Laura Sleggs, ND. I understand and am informed that, as in the practice of other medicine, there are some risks to naturopathic therapies. I do not expect the naturopath to be able to anticipate and explain all risks and the complications, and I wish to rely on Dr. Sleggs to exercise judgment during the course of procedures and therapies which Dr. Sleggs feels at the time, based upon the facts then known, is in my best interests. I understand that homeopathic, nutritional and herbal therapy is administered in an attempt to improve body function, to strengthen health, and thus increase resistance to environmental stresses and diseases. I have been informed that Dr. Sleggs, ND strives to provide and or recommend only the highest quality products for her clients. I will not hold Dr. Sleggs, ND responsible for any adverse reactions due to the quality or manufacturing of any products prescribed by her to me. I understand that no guarantee has been made to me as to the result or cures that may be obtained from suggestions given by this clinic. I intend this consent form to cover the entire course of treatment form my present condition and for any future condition (s) for which I may seek care.

Dr. Sleggs graduated from the Canadian College of Naturopathic Medicine (CCNM) in Toronto, Canada with a doctoral diploma in Naturopathic Medicine (ND). She is licensed as a naturopathic physician in the state of Connecticut and maintains that license with continuing education and standards of practice. New York does not license naturopathic physicians at this time. Dr. Sleggs is not a medical or osteopathic physician (MD or DO) and is not licensed to practice those forms of medicine. Dr. Sleggs has been trained as a primary care physician, able to use modern diagnostic methods with time honored natural remedies to achieve and maintain health.

I understand that my medical records will be kept confidential and will not be released to anyone without my consent, unless required by law. I use chart information for research and educational purposes in order to help further naturopathic care. It will be done anonymously, with no names or personally identifiable information attached. I am responsible for informing Dr. Sleggs if my condition or medications change as treatments may be contraindicated in some conditions (such as pregnancy). By signing here I agree to these policies and I give permission for Dr. Laura Sleggs to work with me as my health care provider.

If the patient is under the age of 18, or is otherwise unable to sign, please complete the following:
I_____ , parent/guardian of _____ consent to treatment given to my child by Laura Sleggs, ND.

Signature: _____Date: _____

Payment Policy Agreement

Full payment for all services and products is due at the time of service. There is a $30 return check fee. If canceling an appointment please provide us with notice at least 24 hours prior to your scheduled appointment. There is a $40 fee for no shows of less than 24 hours notice of cancellation.

I have read and understood the payment and cancellation policy above. By signing here I agree to these policies.

Patient's Signature:_____Date:_____