

Kelley R. Reís  
Naturopathic Physician  
503-693-0904  
The Natural Medicine Center  
172 SE 6<sup>th</sup> Ave  
Hillsboro, OR 97123

## PEDIATRIC INTAKE FORM (6-12 years)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Female: \_\_\_\_ Male: \_\_\_\_\_

Mother's name: \_\_\_\_\_ Father's name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone # (home): (\_\_\_\_) \_\_\_\_\_ Parent's # (work): (\_\_\_\_) \_\_\_\_\_

Parent's e-mail address: \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

### HEALTH HISTORY QUESTIONNAIRE

What are your child's most important health problems? List as many as you can in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Does your child have a contagious disease at this time? Y N

If yes, what? \_\_\_\_\_

#### Previous Illnesses

Rheumatic fever	Y N	German measles	Y N
Chicken pox	Y N	Measles	Y N
Tonsillitis	Y N	approx. number	_____
Ear infections	Y N	approx. number	_____
Other	Y N	list	_____

Has your child had any of the following tests? When Where  
Electroencephalogram (EEG)

.....  
Psychological evaluation

.....  
Hearing tests

.....  
Speech/Language tests

.....  
**Hospitalizations/ Surgeries/ Injuries**

What hospitalizations, surgeries or injuries has your child had?

\_\_\_\_\_  
\_\_\_\_\_

**Immunizations**

Polio	Y N	Pertussis	Y N
Tetanus shot	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Influenza	Y N Any adverse
reactions? Y N	If yes, what ? _____		

**Allergies**

Is your child hypersensitive or allergic to:

Any drugs? \_\_\_\_\_

Any foods? \_\_\_\_\_

Any environmental? \_\_\_\_\_

Breast fed? \_\_\_\_\_ how long? \_\_\_\_\_ Formula? \_\_\_\_\_ milk / soy \_\_\_\_\_

**Typical Food Intake**

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

To Drink: \_\_\_\_\_

Please list **any** prescription medications, over the counter medications, vitamins or other supplements your child is taking:

- |          |          |
|----------|----------|
| 1) _____ | 5) _____ |
| 2) _____ | 6) _____ |
| 3) _____ | 7) _____ |
| 4) _____ | 8) _____ |

## REVIEW OF SYSTEMS

Y = a condition now    P = significant problem in the past    N = never had

### MENTAL/ EMOTIONAL

Mood Swings	Y	P	N	Anxiety/nervousness	Y	P	N
Irritability	Y	P	N	Cries easily	Y	P	N
Hyperactivity	Y	P	N	Unusual fears	Y	P	N
Introvert/extrovert	Y	P	N	Sleep problems	Y	P	N
Motion/car sickness	Y	P	N	Nightmares	Y	P	N

### ENDOCRINE

Heat/cold intolerance	Y	P	N	Fatigue	Y	P	N
Excessive thirst	Y	P	N	Excessive hunger	Y	P	N
Low blood sugar	Y	P	N	High blood sugar	Y	P	N

### SKIN

Rashes	Y	P	N	Eczema, Hives	Y	P	N
Acne, Boils	Y	P	N	Itching	Y	P	N

### HEAD

Headaches	Y	P	N	Head Injury	Y	P	N
Dizzy spells	Y	P	N	High fevers	Y	P	N

### EYES

Glasses or contacts	Y	P	N	Tearing or dryness	Y	P	N
Eye pain/strain	Y	P	N				

### EARS

Earaches	Y	P	N	Impaired hearing	Y	P	N
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### NOSE AND SINUSES

Frequent colds	Y	P	N	Nose Bleeds	Y	P	N
Stuffiness	Y	P	N	Hayfever	Y	P	N
Sinus problems	Y	P	N	Loss of smell	Y	P	N

### MOUTH AND THROAT

Frequent sore throat	Y	P	N	Canker sores	Y	P	N
Breath odor	Y	P	N				

### RESPIRATORY

Cough	Y	P	N	Wheezing	Y	P	N
Asthma	Y	P	N	Bronchitis	Y	P	N

### CARDIOVASCULAR

Heart disease	Y	P	N	Murmurs	Y	P	N
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### URINARY

Frequent urination	Y	P	N	Bed wetting	Y	P	N
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**GASTROINTESTINAL**

Belching/passing gas	Y P N	Stomach aches	Y P N
Constipation	Y P N	Diarrhea	Y P N
Bowel Movements	How often _____		

**MUSCULOSKELETAL**

Joint pain/stiffness	Y P N	Muscle spasms/cramps	Y P N
Broken bones	Y P N		

**BLOOD/PERIPHERAL VASCULAR**

Anemia	Y P N	Easy bleeding/bruising	Y P N
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Is there any information about your child's health that you would like to add?

What expectations do you have for your child from working with our clinic?

Welcome! I'm honored to be of service for you and your child!

# The Natural Medicine Center

503-693-0904  
172 SE 6<sup>th</sup> Ave.  
Hillsboro, OR 97123

Dear New Patient,  
Welcome to our clinic. We look forward to providing for your health needs and encourage your questions and participation in all aspects of your health care.

\_\_\_\_\_  
**Initials**      **Payment for all services and dispensary items is due at the time of the visit.**

\_\_\_\_\_  
**Initials**      **We are not providers on all insurance plans, therefore you may be required to bill your own insurance. We will provide you with all the necessary information for you to send your claim for reimbursement. You have the primary relationship with your insurance company and are responsible for the entire amount that is owed.**

\_\_\_\_\_  
**Initials**      **You will be charged a Missed Appointment fee for any missed appointments or late cancellations (less than 24 hours notice).**

\_\_\_\_\_  
**Initials**      **I give permission for the staff at The Natural Medicine Center to contact me via telephone or email and leave a message that may contain appointment or medical information if I am not available.**

As the patient, you are responsible for the total charges incurred for each visit. We accept MasterCard, VISA, Debit cards, checks, and cash. There will be a charge of \$25.00 for every returned check(s). We can arrange payment plans.

You recognize, understand and agree that your health care provider is a sole practitioner and is not a partner or otherwise affiliated with any other health care providers who may be providing similar services at The Natural Medicine Center. You further recognize, understand and agree that your health care provider is solely responsible for and shall provide all professional services to you, and you are relying solely on your practitioner's skill for the professional services rendered at The Natural Medicine Center.

Your health care provider may prescribe medication, which may be purchased either at The Natural Medicine Center or elsewhere. Most insurance companies do not cover the pharmacy items that we prescribe and dispense.

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I have read and understand the above-stated policies and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

\_\_\_\_\_  
Your Signature (parent signature if minor)

\_\_\_\_\_  
Print your name (parent name if minor & patient name)

\_\_\_\_\_  
Date