DR. TAYLOR BEAN
NATUROPATHIC DOCTOR

CONFIDENTAL PEDIATRIC INTAKE FORM

Thank you for taking the time to complete this intake form to the best of your ability. This is an important step towards defining your child's health care needs. Please be honest with your answers, as this will help me achieve a more suitable treatment plan for your child.

Everything that is share with me both by you and your child is **absolutely confidential.**

Patient Information

Date: _____

First and last name:_____
Age: _____
Gender: _____
Date of birth: (D) (M) (Y)

How did you hear about Dr. Bean? _____

Phone: (home) _____
(cell)_____

(work)_____

May we leave messages relating to your child's visits?

□ Yes □ No

Email:_____

Person to contact in case of an emergency (please include their contact number and relation to child):
_____

Present Health Concerns

Major health concerns (in order of priority)
1. _____
2. _____
3. _____
4. _____

List any **diagnoses** received for any of your child's medical concerns (including who provided the diagnosis):

1. _____ 2. _____

3. _____ 4. _____

Allergies (food, drugs, environmental) and reactions:

1_____

2_____

3_____

4_____

Medications:

	NOW	PAST
Aspirin	_____	_____
Tylenol	_____	_____
Antibiotics	_____	_____
Other_____	_____	_____

Supplements:

	NOW	PAST
Vitamins	_____	_____
Minerals	_____	_____
Fluoride	_____	_____
Other_____	_____	_____

Childhood illnesses:

__ chicken pox
__ red measles
__ mumps
__ rubella
__ scarlet fever
__ rheumatic fever
__ strep throat
__ pneumonia
__ mononucleosis
__ ear infection(s)
__ tonsillitis
__ other_____

<u>Vaccination history</u> – write 'YES' if your child has received the vaccine. Please list if they had a reaction to the vaccine

1. Hepatitis A and B: _____
2. DPT (Diptheria, Pertussis, Tetanus _____
3. MMR (Measles, Mumps, Rubella) _____
4. Small pox _____
5. Chicken pox _____
6. Flu vaccine (how many have you had) _____
7. Polio _____
8. Other _____

Surgeries and hospitalizations (include year):

_____

_____

Mother's health during pregnancy:

Age at pregnancy :_____

□ Alcohol
□ Bleeding
□ Cigarettes
□ Diabetes
□ Drugs
□ Extreme nausea
□ High blood pressure
□ Illness

Any Underlying diseases during pregnancy:

□ Medications
□ Stress
□ Toxemia
□ Trauma/injury
□ X-rays
□ Other:_____

Infant feeding:

□ Breast fed Duration:_____

□ Formula fed Duration:_____Type:_____

Age solids began:_____

What foods are they eating:_____

Food allergy/intolerances:_____

Sample daily diet: choose a typical day, include liquids

_____
_____
_____
_____
_____
_____

Family History

Check mark if the following are in the family. Please write which family member has it:

___ _____ alcoholism
___ _____ anemia
___ _____ asthma
___ _____ eczema
___ _____ heart disease
___ _____hypoglycemia
___ _____ obesity
___ _____ thyroid disorder
___ _____ kidney disease
___ _____ allergies
___ _____ arthritis
___ _____ diabetes
___ _____ epilepsy
___ _____ hearing loss
___ _____ mental illness
___ _____ stroke
___ _____ cancer (what type)

Patient's Health History

Now	Past	Never		Now	Past	Never	
____	____	_____	allergies	____	_____	_____	fatigue
____	____	_____	anemia	____	____	_____	frequent infections
____	____	_____	asthma	____	____	_____	headaches
____	____	_____	bedwetting	____	____	_____	heart murmur
____	____	_____	birth defects	____	____	_____	high fever
____	____	_____	colic	____	____	_____	hyperactivity
____	____	_____	cough/wheeze	____	____	_____	insomnia
____	____	_____	croup	____	____	_____	jaundice
____	____	_____	depression	____	____	_____	learning problem
____	____	_____	diarrhea	____	____	_____	moodiness
____	____	_____	dry skin	____	____	_____	stuffy nose
____	____	_____	earache(s)	____	____	_____	thrush
____	____	_____	eczema/rash	____	____	_____	vomiting spells

others: please list:_____
_____

Review of Symptoms

Height:_____Weight:_____

Any major weight changes in the past year? □ Yes □ No

If yes, how much:_____

Does the child have any medical alerts?_____

How many hours of **sleep** does your child average per night?_____

Does he/she wake rested? □ Yes □ No

Does he/she wake at night? □ Yes □ No If yes, why?_____

CONSENT FORM

Dear patients:

Naturopathic examination includes: physical and clinical diagnosis, Traditional Chinese medical diagnosis and lab work. Therapeutic procedures include: homeopathy, spinal adjustment, botanical medicine, acupuncture, manual muscle therapy, cranio-sacral therapy, clinical nutritional and lifestyle counseling.

Occasionally, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are minimal, it is the practice of my clinic to inform my patients about them. These complications may include, but are not limited to: soreness, inflammation, soft tissue injury, and temporary worsening of symptoms. More serious complications are extremely rare.

I have read and understand the above statements regarding potential treatment side-effects that my child may experience. I also understand that there is no guarantee or warranty for the problem to 100% resolve.

I understand that if I miss an appointment or cancel on short notice (less than 24 hours) I may be charged a fee for the missed appointment.

Signature of Parent/Guardian _____ Date _____

Doctor's Signature _____ Date _____