



jorge kaufmann, ND, LAc, LLC
 5215 ne elam young pkwy, hillsboro, or 97124
 p: 503/693-9101 rosespringscenter.com

PEDIATRIC INTAKE FORM (BIRTH TO 5 YEARS)

Patient's Name: _____ Date: _____

Age: _____ Date of Birth: _____ Gender: Female / Male

Parent/Guardian's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone (home): _____ (Parent's work): _____

Parent's email address: _____

How did you hear about this clinic? _____

If internet: Google: _____ AANP Website: _____ OANP Website: _____ Other: _____

Has any other family member already been a patient at this clinic? _____

Name of doctor's office/hospital/clinic where your child's health records are kept: _____

Reason for referral or presenting problems: _____

MEDICATIONS

NOW	PAST		NOW	PAST	
_____	_____	Aspirin	_____	_____	Decongestants
_____	_____	Tylenol	_____	_____	Anti-histamine
_____	_____	Antibiotics	_____	_____	Other _____
_____	_____	Ibuprofen	Allergies to medicines: _____		

MEDICAL HISTORY

_____ Chicken pox	_____ Scarlet fever	_____ Tonsillitis, approx no. of times: _____
_____ Measles	_____ Pneumonia	_____ Ear infections, approx no. of times: _____
_____ Mumps	_____ Frequent colds	_____ Strep throat, approx no. of times: _____
_____ Rubella	_____ Rheumatic fever	_____ Other: _____

Has your child ever had any of the following?

WHEN WHERE RESULTS

Electroencephalogram (EEG): _____

Psychological evaluations: _____

Hearing test: _____

Speech/language tests: _____

Injuries/surgeries/hospitalizations (please list): _____

IMMUNIZATIONS

_____ MMR	_____ DPT	_____ Chicken pox	Others: _____
_____ Measles	_____ Diphtheria	_____ Small pox	Adverse reactions: Y / N
_____ Mumps	_____ Tetanus	_____ H. influenza	If so, what? _____
_____ Rubella	_____ Polio	_____ The flu	_____

PLEASE FILL OUT BOTH SIDES



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FAMILY HISTORY

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Birth defects |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Mental illness | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other significant: _____ |

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications: _____

Mother's age at child's birth: _____

Mother's health during pregnancy:

- | | | |
|--------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Nausea | <input type="checkbox"/> Physical or emotional trauma |
| <input type="checkbox"/> Illnesses | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Cigarettes, alcohol, drug consumption |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid problems |

BIRTH HISTORY

Term: Full Premature Late Weight at birth: _____

Length of labor: _____ Complications: _____

City/State where born: _____ Time child was born: _____

Did your child have any of the following problems shortly after birth?

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Birth injuries | <input type="checkbox"/> Blue baby |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Seizures | <input type="checkbox"/> Cerebral palsy |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Fever | <input type="checkbox"/> Birth defects |
| <input type="checkbox"/> Other: _____ | | |

Child's sleep patterns (1st year): _____

Food intolerances: _____

Breast fed: Y / N How long: _____ Formula: Y / N Type (milk, soy): _____

Age began solids: _____ Which foods: _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS

- | | | | |
|---------------------------------------|---|---|--|
| <input type="checkbox"/> Hives | <input type="checkbox"/> Burning urine | <input type="checkbox"/> Bloody uring | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Cries easily | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Vomiting spells | <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Anemia | <input type="checkbox"/> Night sweats | <input type="checkbox"/> High fevers |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sensitive to light | <input type="checkbox"/> Chronic rash | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Sore throats |
| <input type="checkbox"/> Flat feet | <input type="checkbox"/> No appetite | <input type="checkbox"/> Body/breath odor | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Unusual fears |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Joint pains | <input type="checkbox"/> Excessive fatigue | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Dizzy spells | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Allergies |

DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

THANK YOU. I LOOK FORWARD TO HELPING YOUR CHILD IN ANY WAY I CAN.