

NATURAL HEALING, LLC
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PEDIATRIC INTAKE FORM

Date: _____

Patient's Name: _____ **Age:** _____ **Sex:** _____ **Birth date:** _____

Name of Parent or Guardian: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone(home): _____ **(work):** _____ **E-mail:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Patient's Primary Care Physician/Pediatrician: _____

How did you hear about Dr. Donar? _____

What is your main reason for coming in today? _____

Onset of this condition: _____

Additional health concerns:

1. _____
2. _____
3. _____

Medications (Please list the name of the drug and length of time used)

Vitamins and/or herbal supplements

Allergies (to medications, supplements, food, environment)

Has your child had or currently have any of the following? N= Now, P= Past

Measles _____	Mumps _____	Scarlet Fever _____
Heart Murmur _____	Frequent colds _____	Headaches _____
Rashes _____	Pneumonia _____	Ear infections _____
Bed wetting _____	Diarrhea _____	Constipation _____
Insomnia _____	Cough/wheezing _____	Indigestion/gas _____
Anxiety _____	Strep throat _____	Behavioral Disorder _____

FAMILY HISTORY

Family member(s)

Allergies _____

Alcoholism _____

Asthma _____

Autoimmune Disorder _____

Bleeding Disorder _____

Cancer _____

Diabetes _____

Epilepsy _____

Heart Disease _____

Learning Disability _____

HEALTH AND LIFESTYLE HABITS

Is your child exposed to cigarette smoke/fumes? _____

How often does your child eat/drink the following?

Soda _____

Fruit juice _____

Water _____

Caffeine _____

Sweets _____

Pasta _____

Dairy products _____

Fresh fruits/vegetables _____

Bread _____

ADDITIONAL CONCERNS/COMMENTS

***Thank you for taking the time to fill out this form**