

CURRENT MEDICATIONS, VITAMINS, & OTHER SUPPLEMENTS: (Please include dosages)

HOSPITALIZATIONS, SURGERIES, OR SERIOUS INJURIES: (Please include dates)

ALLERGIES (drugs, food, or other substances):

PRENATAL/BIRTH/FEEDING HISTORY

Please list any health problems *mother* experienced during pregnancy with this child: _____

Term of pregnancy (circle one): Full Premature Late Birth Weight: _____

Any complications with delivery (circle one)? No Yes; _____

Place of Birth (circle one): Hospital Home Clinic Other: _____

Feeding (Please applicable):

Breast Fed: No Yes; How long? _____

Formula: No Yes; What type(s): _____ How long? _____

Age solid foods began: _____ What foods: _____

Food Intolerances: No Yes; (list foods) _____

Favorite foods: _____

24-hour Food/Drink Intake (please list yesterday): _____

SOCIAL HISTORY

Are parents (circle one): Married / Separated / Divorced / Other: _____

Mother's occupation: _____; Full-time / Part-time

Father's occupation: _____; Full-time / Part-time

Guardian: _____; Relationship: _____

Other's residing in home? No Yes; _____ Relationship: _____

Daycare? No Yes; Where: _____

Siblings? No Yes; (please list names, ages, and any health problems below:

FAMILY HISTORY

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS/HIV+ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Allergies/hay fever | <input type="checkbox"/> Gout | <input type="checkbox"/> Senility |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cervical cancer | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Ovarian cancer | <input type="checkbox"/> Loss of height | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Prostate cancer | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Uterine cancer | <input type="checkbox"/> Migraines | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Other cancer: _____ | <input type="checkbox"/> Obesity | <input type="checkbox"/> Other: _____ |

OTHER INFORMATION

Is there anything else you would like the doctor to know about you/your child?

Consent of Financial Responsibility:

The ultimate responsibility of the fees is that of the undersigned/patient. **Patients are requested to provide 24-hour notice of cancellation. Without such notice, clients will be charged for the professional time at the regular hourly rate.** Your signature indicates your understanding and acknowledgement of the foregoing information. *Please sign your name:* _____ *Date:* _____

Please return this intake form to:

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