Restoring to Health with Homeopathy
www.restoringtohealth.com
Kelley Palomino, Homeopath

Pediatric Intake Form

Name_____ **Birth date** _____ **Age** _____

School Grade: **School Name:**

Reason for Visit:

Birth History Birth weight_____ Weeks_____ ☐ Full term ☐ Preterm APGARS_____
☐ Vaginal ☐ C-section ☐ Reason for C-section _____

Medications During Pregnancy ☐ None ☐ Prenatal Vitamins
☐ Other (please name): _____

Mom's Pregnancy

☐ Uncomplicated
☐ Early Labor
☐ Hyperemesis (excessive vomiting)
☐ Bleeding
☐ Diabetes
☐ Thyroid problems
☐ Pre-eclampsia
☐ Physical or emotional trauma

Post Natal Complications

☐ None
☐ Jaundice
☐ Respiratory
☐ Cardiac
☐ Other _____
☐ Infections
☐ Gastrointestinal
☐ Hospitalized. How lonq?
_____

Developmental History Rolled over at _____ Crawled at _____ Walked at _____ Sat up at _____
Talked at _____ Solid food at _____ ☐ Breastmilk ☐ Formula ☐ Other: _____
Has (s)he stopped or had regression of speech? ☐ No ☐ Yes

Medical History

☐ Allergies
☐ Asthma
☐ Breath-holding spells
☐ Chickenpox
☐ Colic
☐ Dehydration
☐ Ear infections
  ☐ none
  ☐ rarely
  ☐ many
☐ Eczema
☐ Encephalitis
☐ Frequent colds
☐ Measles
☐ Meningitis
☐ Passing out (syncope)
☐ Pneumonia
☐ Previous surgeries (please list dates)
_____
_____
☐ Seizures
  ☐ With fever
  ☐ Without fever
☐ Strep throat
☐ Tonsillitis

Symptoms

☐ Hives
☐ Cries easily
☐ Nose bleeds
☐ Acne
☐ Jaundice
☐ Diarrhea
☐ Wheezing
☐ Vomiting spells
☐ Joint pains
☐ High fevers
☐ Dizziness
☐ Anemia
☐ Low appetite
☐ Fatigue
☐ Constipation
☐ Frequent urination
☐ Stomach aches
☐ Headaches
☐ Warts
☐ Hair loss
☐ Cough
☐ Rashes

Immunizations

☐ All received ☐ Standard schedule ☐ Delayed schedule

☐ HIB ☐ Pneumococcal ☐ Diptheria ☐ Pertussis ☐ Tetanus ☐ Measles ☐ Mumps ☐ Rubella ☐ Hep B ☐ Varicella ☐ Polio EIPV

Other? Any reactions to immunizations? Please describe:

Medications/Supplements

Name	Dose	Taking? Y/N		Name	Dose	Taking? Y/N

Family History					
Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if your **blood relatives** had any of the following and list their relationship to you
Father					☐ Allergies _____ ☐ Gonorrhea _____
Mother					☐ Aneurysm _____ ☐ Headaches/Migraines _____
Brothers					☐ Anxiety _____ ☐ Heart Disease _____
					☐ Arthritis, Gout _____ ☐ High Blood Pressure _____
					☐ Asthma _____ ☐ Kidney Disease _____
					☐ Autism_____ ☐ Learning Disabilities _____
					☐ Brain Tumor _____ ☐ Manic Depression _____
Sisters					☐ Cancer (type) _____ ☐ Mental Retardation _____
					☐ Cerebral Palsy _____ ☐ Obsessive Compulsive DO _____
					☐ Chemical Dependency _____ ☐ Schizophrenia _____
					☐ Depression _____ ☐ Syphilis _____
					☐ Diabetes _____ ☐ Tics _____
					☐ Epilepsy/Seizures _____ ☐ Tuberculosis _____

Typical Diet:

Favorite foods:_____

Foods avoided/eliminated: _____

Academics

Areas of strength:_____

Areas of difficulty:_____

Teacher comments: _____

Behavior Problems: _____

History of

☐ Biting
☐ Hitting
☐ Head banging
☐ Aggressiveness
☐ Unable to comfort
☐ Odd fascinations
☐ Bed wetting
☐ Stuttering
☐ Teeth grinding at night
☐ Teeth grinding in the day
☐ Pulling own hair
☐ Nursing difficulty
☐ Nail biting

Sensitivity to

☐ sound
☐ touch
☐ smells
☐ lights

How is his/her play? ☐ Appropriate ☐ Inappropriate **Interacts with other children?** ☐ Very well ☐ Average ☐ Poorly

Abnormal Movements ☐ None ☐ Excessive turning ☐ Hand flapping ☐ Other_____

Sleep Pattern ☐ Normal ☐ Difficulty falling asleep ☐ Frequent waking ☐ Nightmares ☐ Night terrors ☐ Other_____

Sleep Position ☐ Side ☐ Back ☐ Abdomen ☐ Arms over head ☐ Restless ☐ Other_____

Perspiration ☐ None ☐ Heavy: ☐ Head ☐ Body ☐ Hands ☐ Feet ☐ Other_____

Vision: Vision tested? ☐ Yes ☐ No If yes, what were the findings?_____

Hearing: Hearing tested? ☐ Yes ☐ No If yes, what were the findings?_____

Excessive fears

☐ Water
☐ Being alone
☐ Dark
☐ Monsters/Ghosts
☐ Thunder/Storms
☐ Strangers
☐ Animals Which ones?_____

Other: _____