



Longmont Healing Arts Clinic

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(720) 652-9972 www.longmonthealingarts.com

Pediatric Intake Form

Date: _____ Child's name: _____

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

Address: _____

Phone: Home _____ Work _____ Cell _____

Mother's Name: _____ Father's Name: _____

Brothers' and Sisters' names and ages _____

Name of Pediatrician: _____ Phone: _____

How did you hear about our clinic? _____

HEALTH HISTORY

Most important health concerns:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

MEDICAL HISTORY

Chicken pox	Scarlet Fever	Tonsillitis	Frequent Colds
Measles	Pneumonia	Ear infections	Rheumatic Fever
Mumps	Rubella	Strep throat	Mononucleosis
Eczema/Skin Problems	Asthma/Wheezing	Allergies	Croup
Handicaps/Disabilities	Diabetes	ADD	Hyperactivity
Emotional Disorders	Suicide attempts	Heart Defect	High/Low Blood Pressure
Hives	Bleeding gums	Nose bleeds	Sleep problems
Acne	Anemia	Easy bruising	Hearing loss
Flat feet	Loss of appetite	Body/Breath odor	Constipation/Diarrhea
Unusual Fears	Fatigue	Nightmares/terrors	Joint pains
Dental Problems	Bed Wetting	Discipline Problems	Developmental Problems
Eye Problems	Speech Problems	Urinary Problems	Seizures

Other: _____

Hospitalizations and/or Surgeries: _____

MEDICATIONS – prescription and over the counter

Aspirin decongestants antibiotics
Tylenol anti-histamine ibuprofen
Other: _____

SUPPLEMENTS – vitamins, minerals, herbs, homeopathics

ALLERGIES

Please list any allergies and sensitivities to drugs, environment or food:

VACCINATIONS

Diphtheria Measles/Mumps/Rubella Pertussis Chicken Pox
Polio Hepatitis B Pneumococcal HPV
Tetanus Influenza Other: _____

FAMILY HISTORY

Please indicate if any family member has/had any of the following:

	Family Member		Family Member
Heart Disease	_____	Diabetes	_____
Birth Defects	_____	Allergies	_____
High Blood Pressure	_____	Arthritis	_____
Tuberculosis	_____	Asthma	_____
Mental Illness	_____	Osteoporosis	_____
Cancer	_____	Depression/Anxiety	_____
Alcoholism/Addictions	_____	Bleeding Disorders	_____

PRENATAL HISTORY

Mother's age at child's birth: _____

Mother's health during pregnancy:

Bleeding	Nausea	Physical Trauma	Emotional Trauma
High Blood Pressure	Low Blood Pressure	Diabetes	Thyroid Problems
Cigarettes, Alcohol, Drug consumption			

Illnesses: _____

Medications: _____

BIRTH HISTORY

Term: full / premature / late Length of labor: _____

Any complications? _____

Birth weight: _____ Birth length: _____

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

Rashes	Birth injuries	Colic	Birth Defects
Jaundice	Seizures	Cerebral Palsy	Fever

Other: _____

Breast fed? Yes No How long? _____ Formula? Yes No How long/type? _____

Age began solid food: _____

DIET HISTORY

Please describe your child's typical diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Any trouble introducing foods? If yes, which foods and what were the difficulties?

Thank You!

I look forward to working with you and your child towards optimal health
and well-being!

~Dr. B.