Longmont Healing Arts Clinic
Barbara Vaelli, ND, LAc
736 Kimbark Street, Suite A
Longmont, CO 80501
(720) 652-9972

Pediatric Intake Form

Date:__________ Child's name:____

Date of Birth:________________ Age:______ Gender: Male Female

Mother's Name:____________________________ Father's Name:__________________________________

Adress:____

Daytime Phone Number(s): ____

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: ____
____

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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

Diptheria	Measles/Mumps/Rubella	Pertussis	Chicken Pox
Polio	Hepatitis B	Pneumococcal	HiB
Tetanus	Influenza	HPV	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:____

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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:

Breaksfast:______________________________

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. V.