Madeleine Morrison N.D. LLC
Pediatric Intake (0-puberty)

Date_____

Name_____ Age_____ Sex ___ Birthdate _____
Who is filling out this form (name and relation)_____
Contacts for this child:
Name: _____ Phone: _____ h c w
Address: _____ Phone: _____ h c w
_____ Relation to child: _____

Name: _____ Phone: _____ h c w
Address: _____ Phone: _____ h c w
_____ Relation to child: _____

With whom does this child live with? _____
If parents divorced, is custody 50:50 _____ If not what is the arrangement? _____
Is medical/legal custody joint authority? _____ if not who has legal/medical custody? _____

Other Healthcare Providers:
Name: _____ Name: _____
Profession: _____ Profession: _____
Phone: _____ Fax: _____ Phone: _____ Fax: _____
Dentist: _____ Regular visits? Y N More than 3 fillings Y N
Orthodontist: _____ Other _____

List your child's health concerns in order of importance and include the date of onset:
1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
How would you describe your child's present state of health? Excellent good fair poor

Medications and supplements (name, brand) dosages:
1. _____ 3. 3. _____ 5. 5. _____
2. _____ 4. 4. _____ 6. 6. _____

Birth History:
If your child is adopted please share; country of origin, health of birth parents, age of adoption etc.

Health of **mom** at time of conception? Poor Good Excellent Unknown
Health of **dad** at time of conception? Poor Good Excellent Unknown
Did mom receive prenatal care? _____ Prenatal vitamins? _____
Any difficulties of pregnancies (vomiting, bleeding, hypertension)? _____
Did mom smoke cigarettes? _____ Drink alcohol? _____
Use illicit drugs? _____ Use medications? _____
Above how often? and what used?
What type of birth did this child have (home, c-section, hospital)? _____
Was baby born at pre 37 weeks 37 weeks 38 weeks 39-41 weeks (term) 41-42 weeks or _____
Was labor induced? _____ How long was labor approx.? _____
Any complications of labor or delivery? _____
Any health issues post birth? _____

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Medical History

Please indicate any serious illnesses, injuries, hospitalizations, or other trauma's and approximate dates:

1. _____
2. _____
3. _____

Which of the following has your child had or been immunized?

V=vaccinated Pv=partially vaccinated S=sickness N=never

Rubella _____
Measles _____
Mumps _____
Polio _____
Tetanus _____
Pertussis _____
Diptheria _____
Influenza _____

Rotavirus_____
Hib _____
Hep A _____
Hep B _____
Meningococcal _____
HPV _____
Chicken pox _____
Shingles _____

Which has your child had of the following? If any
Y=yes (and when) N=no

Strep throat _____
Scarlet fever _____
Influenza _____
Impetigo _____
Mononucleosis _____
Ear Infections _____
Gastroenteritis _____
Food poisoning _____

Has your child been treated with antibiotics? How many times? _____
_____

Has your child had any **adverse reactions** to herbs, medications or immunizations? _____
_____

Please list any **allergies** your child has, how they became known and if there is any medical attention needed for a reaction? (medication, environmental, food)

_____
_____

Has your child had any screening tests (blood, hearing, vision etc.)? _____
_____

Did this child breastfeed? _____ For how long? _____ Any difficulties? _____
Was supplemental milk used? _____ What kind or brand of formula? _____
Any issues with formula use? _____
Did the child experience **colic**? Age _____ mild moderate severe

How was your child's **first year** health wise? Poor Fair Good Excellent Unknown

At what age did your child:

Sit up _____
Crawl _____
aWalk _____
aTalk (3 plus words) _____

Does your child attend **school**? *Y* or *home schooled* Which school? _____ Grade _____
Describe your child's attitude and behavior around school? _____
_____
_____

Describe the child's **sleep pattern**: _____
_____

How were **foods introduced** to child, if they have been? At what age, approximately? _____
_____

Child over 2 yr. old: Are there any foods restricted from the child's diet (religious, vegan, etc)?

_____
_____

Describe a **typical day's diet** for your child and time eaten:
Breakfast:

_____

Lunch:

_____

Snack:

_____

Dinner:

_____

Drinks:

_____

Family History

Please indicate below **any family occurrences**, parents, siblings, maternal grandparents (MGP), paternal grandparents (PGP), aunts, or uncles. If death occurred please indicate age if known.

Alcoholism _____
Allergies _____
Alzheimer's Disease _____
Arthritis _____
Asthma _____
Tuberculosis _____
Depression _____
Epilepsy _____
Skin conditions _____
Diabetes _____
Drug abuse _____
Heart Disease _____
High Blood Pressure _____
Kidney Disease _____
Osteoporosis _____
Stroke _____
Thyroid condition _____
Anemia _____
Glaucoma _____
Gastrointestinal Issue _____
Cancer _____
Obesity _____
Other _____

Does either **parent** have a chronic illness or ever-received treatment for an illness? If yes please describe:

_____
_____

Has your child have/had any of the following issues:

Problems with hearing/speech _____
Eye or Vision _____
Headaches _____
Seizures _____
Nasal Allergies _____
Asthma _____
Bronchitis/Pneumonia _____
Heart problems _____
Anemia _____
Bleeding problems _____
Abdominal pain _____
Constipation _____
Bladder/Kidney _____
Bed wetting (after 5) _____
Chronic skin rash _____
Diabetes _____
Thyroid _____
Weight issues _____

Does anyone in the family, attending or living with the child smoke? _____
Does anyone living with or attending to the child use alcohol or marijuana daily? _____
Does anyone living with or attending the child have a moderate to severe psychiatric illness? _____

_____

Daily Life

Who lives with this child on a regular basis in the home? (30% or greater amount of time) Please include names and ages of siblings_____
_____
_____
_____
Does this child sleep over at anyone's house on a regular basis? _____
_____

Please describe the **emotional climate** of your home:_____
_____

Rate the general **stress** level of your family and circle the primary contributors: (1=low, 10= high)
1 2 3 4 5 6 7 8 9 10 Health Money Work Family Marriage Children

In your everyday life, your **faith /spiritual practices** are (less important, highly important)
1 2 3 4 5 6 7 8 9 10 Time devoted daily on average? _____

What does this child do daily? And approximately for how much time?
School _____ Time _____ Homework _____ Time _____
Sports _____ Time _____ Music _____ Time _____
Other creative pursuits _____ Time _____
Computer games _____ Time _____ Reading _____ Time _____
TV/ Movies / Netflix _____ Time _____ Chores _____ Time _____
Playing (Alone) _____ Time _____ (with friends) _____ Time _____

Do you and this child feel **motivated** to make changes for better health? (1=unmotivated, 10 motivated)
Parent 1 2 3 4 5 6 7 8 9 10 ***Child*** 1 2 3 4 5 6 7 8 9 10
If child lives with another person part time is there going to be issues with changes or supplements?
_____

What brings this child **joy**? Animals, reading, sports etc.… _____
_____
What are your child's **favorite activities**? _____
_____

Does your child **exercise** regularly? How frequently and what activities?
_____
_____

Any divorce, deaths, pets, foods, people, or unusual activity that is relevant to this child's history?
_____
_____
_____

Thank you for your time and brain power. Now I get to read the test so please give me a minute or two. Thanks for your time and sharing your prized possession with me.