



Amber Golshani N.D.

Treating the cause, naturally

Pediatric Intake Form

Full Name _____ Date of birth _____ Sex M or F

Grade and Name of School: _____

Address: _____

City: _____ State: _____ Zip: _____

Mother's Full Name and occupation: _____

Father's Name and occupation: _____

Phone Number: _____

Parents are (circle): Married Separated Divorced Living Together Other

Parents Email Address: _____ Recieve E-News? Y or N

Regular Pediatrician name and city located in: _____

Reason for Office Visit: _____

Has child been seen by any other doctor(s) for this complaint? Yes No Past

Has child had any blood work done? If yes, please list what:

Please list any operations or hospitalizations and year occurred:

- 1.
- 2.
- 3.

Please list all medicines (drugstore or prescription) child is on, dose and for how long?

- 1.
- 2.
- 3.
- 4.

Please list all supplements child is taking, dose and for how long?

- 1.
- 2.
- 3.
- 4.

Please list any other Doctors/Therapists/Healers child is seeing and for what reason?

Previous medical history

Yes indicates the child gets the problem regularly; No indicates the child never had the problem; Past indicates the child had the problem in the past but not recently. Please circle the correct one for your child.

Ear Infections? Yes No Past

If has had, how many total? _____

Colds? Yes No Past

If has had, how many total? _____

Strept throat? Yes No Past

If has had, how many total? _____

How many times has the child taken antibiotics: _____

What other medicines has the child taken? And how often?

- 1.
- 2.
- 3.
- 4.

Hearing tests Normal: Yes No Not Tested

Vision Tests Normal: Yes No Not Tested

Any speech impediments: Yes No Past

Learning impediments: Yes No Don't know

Vaccination History: Yes, has had; No, has not; Some, did not finish all shots

MMR: Yes No Some

DPT: Yes No Some

Hep B: Yes No Some

Hib: Yes No Some

Chickenpox: Yes No Some

Polio: Yes No Some

Other: _____

Any reactions to vaccinations? If so, please explain: _____

Family history

Allergies: Yes No

Cancer: Yes No

Cardiovascular disease: Yes No

Diabetes mellitus: Yes No

Obesity: Yes No

Tuberculosis: Yes No

Mental Illness: Yes No

Mother's Pregnancy history

Age at conception: _____ Did she have other children already? Yes No

Health During Pregnancy:

Mothers emotions during pregnancy _____

Smoking: Yes No

Diabetes: Yes No

Coffee: Yes No

Nausea/Vomiting: Yes No

Recreational drugs: Yes No

Emotional Stress: Yes No

Preeclampsia: Yes No

Length of Labor: _____

Vaginal birth: Yes No

Traumatic birth: Yes No

If the birth was difficult, please explain:

Health of baby at birth: _____

Child breastfed: Yes No

For how long: _____

When put on formula: _____

What formula was used: _____

When was child put on solid food: _____

When did child Walk: _____

Talk: _____

Develop Teeth: _____

Health History of child

Jaundice as baby: Yes No

Colic: Yes No

Cradle cap: Yes No

Anemia: Yes No

Eczema or psoriasis: Yes No

Asthma: Yes No

Diarrhea: Yes No

Warts: Yes No

Constipation: Yes No

Nightmares: Yes No

Finicky eating: Yes No

Bed-wetting: Yes No

Poor teeth: Yes No

Tantrums: Yes No

Chronic sniffles: Yes No

Disobedient: Yes No

Bad foot odor: Yes No

Fears/Phobia: Yes No

Very sweaty baby/child: Yes No

Diaper Rash: Yes No

Hyperactivity: Yes No

Early Puberty: Yes No

Growing pains: Yes No

Stomach aches: Yes No

Any particular household stressors child has witnessed or gone through:

1. _____

2. _____

3. _____

Known Allergies to Food, Medicines, Pollens, Dander, etc.:

Typical Day's Diet:

Breakfast: _____

Snack: _____

Lunch: _____

Snack: _____

Supper: _____

Snack: _____

Sleep:

Does your child nap? If so for how long? _____

Time to bed at night? _____ Time of waking in morning? _____

Does child wake at night? If so, why? _____

Toxin Exposure:

Has the child ever lived near a refinery or other highly polluted area? _____

Has the child ever lived in a house with lead paint? _____

Has the child ever lived in a house that had new paint, cabinets, carpeting installed and did that seem to affect their health at all? _____

Do you spray pesticides or herbicides around the house or use other toxic chemicals?

Does the child seem particularly sensitive to perfumes or other vapors? _____

Social History

How is your child with friends? _____

Meeting new people or situations? _____

In three words, my child is _____