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CHILD NEW PATIENT INTAKE FORM

Name: _____ Date of birth: mm / dd / yyyy

Gender: _____

Parent names: _____

Address: _____

Phone numbers

Home _____ Cell _____ Email: _____

Do you consent to receive occasional emails from Dr. Jenny and/or Momentum Therapy? Yes No

Parents' occupations

Current: _____

Occupations in the past: _____

Emergency contact

Name: _____ Phone number: _____ Relation: _____

Family doctor/pediatrician

Name: _____ Address: _____

Phone number: _____

Other health care providers

Name: _____ Specialty: _____ Phone number: _____

How did you hear about the ND? _____

Please describe your child's primary health concerns

Which therapies have been tried? Have they helped?

Please list any other health concerns your child may have

Personal medical history

Please list any medical conditions, serious illnesses, injuries, and diagnoses your child has received now or in the past, dates, and how they were diagnosed

Has your child:

Been sick often? No Yes _____

Ever been hospitalized? No Yes _____

Received any surgeries? No Yes _____

Taken or now takes antibiotics? No Yes How many times? _____

Taken or now takes any other medications (including over the counter)? No Yes _____

Taken or now takes any supplements/vitamins? No Yes _____

Any allergies (food, environmental, medical)? No Yes _____

Even had (please check all that apply, and indicate age, and the number of times):

<input type="checkbox"/> Rubella	<input type="checkbox"/> Measles	<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Mumps
<input type="checkbox"/> Roseola	<input type="checkbox"/> Scarlet fever	<input type="checkbox"/> Whooping cough	<input type="checkbox"/> Strep throat
<input type="checkbox"/> Impetigo	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Fifth's disease

Please check which vaccinations your child received, and indicate at which age:

<input type="checkbox"/> DPT	<input type="checkbox"/> MMR	<input type="checkbox"/> Haemophilus influenza B	<input type="checkbox"/> Influenza (flu)
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Chicken pox	<input type="checkbox"/> HPV
<input type="checkbox"/> Rotavirus	<input type="checkbox"/> RSV	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Polio

Have there ever been adverse reactions to vaccines? No Yes _____

Has you child ever received specialized screening tests: No Yes _____

Prenatal and Birth history

Health of the mother before conception: Good Fair Poor Unknown

Health of the mother during pregnancy: Good Fair Poor Unknown

Has the mother experienced any of the following during pregnancy:

- Bleeding Diabetes High blood pressure Vomiting Thyroid issues
- Physical trauma Emotional trauma Cigarette smoking Drug use Alcohol use

Was there prenatal care provided by a healthcare provider? No Yes Unknown

Child's birth:

Induced? Vaginal? C-section? Number of weeks:_____ Length of labor:_____

Were there any difficulties or complications? No Yes _____

Were antibiotics used during labor? No Yes

Child's weight and height at birth: _____

Nutrition

Child's feeding: Breastfed Formula fed Both

Please describe solid food introductions, including type of food and age of introduction:

Have any food sensitivities? _____

Does your child have dietary restrictions (eg. vegetarian, vegan, religious, etc)? No

Yes _____

Please describe your child's diet on a typical day:

Breakfast: _____

Lunch: _____

Dinner: _____

Snack: _____

Beverages (including water): _____

Development and lifestyle

Age when you child began:

Sitting _____ Crawling _____ Walking _____ Talking _____

How would you describe your child's overall development?

Physically: Average Slow Fast Mentally: Average Slow Fast

Has your child started puberty? No Yes. At what age? _____

Please describe your child's sleep patterns and any difficulties with sleep:

Please describe your child's temperament:

Is your child: At home? At school? At daycare? Other: _____

Please describe your child's behavior and performance at day care/school, and their attitude towards it:

Please describe your child's interests and extra-curricular activities:

How much screen time does your child get? What type of exercise do they get per day?

Who does the child live with? _____

Does anyone in the household smoke? No Yes

Are there pets at home? No Yes _____

Is the child exposed to any noxious chemicals, toxins, or other hazards? No

Yes _____

Please describe the emotional climate of your household and its stress levels:

Family history

Please indicate which conditions are present in your family, and which family member has the conditions in relation to your child (eg. father, sister, maternal grandmother, etc)

Check here if you do not know your family history

<input type="checkbox"/>	Alcoholism/addiction	<input type="checkbox"/>	Heart disease
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	High cholesterol
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Liver disease
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Eczema/psoriasis	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Depression/other mental illness
<input type="checkbox"/>	Headaches/migraines	<input type="checkbox"/>	

Any other conditions that have not been listed? _____

Review of body system

Please place a check mark ✓ beside any issues your child currently experience, or a **P** beside issues that your child had in the past

General <input type="checkbox"/> Unintentional weight loss <input type="checkbox"/> Unexplained weight gain <input type="checkbox"/> Fatigue <input type="checkbox"/> Weakness <input type="checkbox"/> Poor sleep/insomnia/nightmares <input type="checkbox"/> Sweating and/or night sweats	Emotional <input type="checkbox"/> Depression/cries easily and often <input type="checkbox"/> Anxiety/nervousness <input type="checkbox"/> Mood swings/irritability <input type="checkbox"/> Fears/phobias <input type="checkbox"/> Substance abuse <input type="checkbox"/> Eating disorder <input type="checkbox"/> History of abuse	Skin and hair <input type="checkbox"/> Rashes/hives <input type="checkbox"/> Acne <input type="checkbox"/> Discoloration <input type="checkbox"/> Dryness <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Itching <input type="checkbox"/> Temperature changes <input type="checkbox"/> Moles
Head <input type="checkbox"/> Headaches <input type="checkbox"/> Head injury <input type="checkbox"/> Dizziness	Nose and sinus <input type="checkbox"/> Impaired sense of smell <input type="checkbox"/> Frequent colds/ sinus infections <input type="checkbox"/> Congestion <input type="checkbox"/> Itching <input type="checkbox"/> Discharge <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Post-nasal drip <input type="checkbox"/> Polyps or deviated septum	Eyes <input type="checkbox"/> Impaired vision <input type="checkbox"/> Glasses/contacts <input type="checkbox"/> Eye pain <input type="checkbox"/> Redness <input type="checkbox"/> Itchiness <input type="checkbox"/> Discharge <input type="checkbox"/> Dry eyes <input type="checkbox"/> Blurring/double vision <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts
Ears <input type="checkbox"/> Impaired hearing <input type="checkbox"/> Earache <input type="checkbox"/> Discharge <input type="checkbox"/> Frequent ear infections		
Mouth and throat <input type="checkbox"/> Frequent sore throat <input type="checkbox"/> Tonsilitis or laryngitis <input type="checkbox"/> Hoarseness <input type="checkbox"/> Canker sores <input type="checkbox"/> Cold sores <input type="checkbox"/> Loss of taste <input type="checkbox"/> Dental/gum issues <input type="checkbox"/> Jaw pain <input type="checkbox"/> Goiter <input type="checkbox"/> Swollen glands	Respiratory <input type="checkbox"/> Asthma/wheezing <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Cough <input type="checkbox"/> Phlegm <input type="checkbox"/> Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Tuberculosis	Cardiovascular <input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations/fluttering <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmurs <input type="checkbox"/> Rheumatic fever
Gastrointestinal <input type="checkbox"/> Change in appetite <input type="checkbox"/> Change in thirst <input type="checkbox"/> Trouble swallowing <input type="checkbox"/> Heartburn <input type="checkbox"/> Indigestion <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Belching <input type="checkbox"/> Ulcers <input type="checkbox"/> Excessive gas <input type="checkbox"/> Bloating <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Changes in stool quality <input type="checkbox"/> Changes in stool frequency <input type="checkbox"/> Liver/gall bladder disease <input type="checkbox"/> Worms/parasites	Urinary <input type="checkbox"/> Pain on urination <input type="checkbox"/> Difficult urination <input type="checkbox"/> Frequent urination <input type="checkbox"/> Bedwetting <input type="checkbox"/> Frequent infections <input type="checkbox"/> Blood in the urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Kidney stones <input type="checkbox"/> Kidney disease	Female reproductive Age of first period _____ Length of cycle _____ Length of period _____ <input type="checkbox"/> Irregular cycle <input type="checkbox"/> Very short or very long cycle <input type="checkbox"/> No periods <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Heavy periods <input type="checkbox"/> Scanty periods <input type="checkbox"/> Painful periods <input type="checkbox"/> PMS <input type="checkbox"/> Breast tenderness <input type="checkbox"/> Ovarian cysts <input type="checkbox"/> Uterine fibroids <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Vaginal itching <input type="checkbox"/> Yeast infections
	Endocrine <input type="checkbox"/> Heat/cold intolerance <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Changes in thirst/hunger <input type="checkbox"/> Diabetes <input type="checkbox"/> Blood sugar problems <input type="checkbox"/> Hormonal problems	

<p>Breast</p> <ul style="list-style-type: none"> <input type="checkbox"/> Lumps <input type="checkbox"/> Pain <input type="checkbox"/> Nipple discharge 	<p>Neurological</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fainting <input type="checkbox"/> Seizures <input type="checkbox"/> Paralysis <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Memory loss <input type="checkbox"/> Balance/gait problems <input type="checkbox"/> Difficulty with movement 	<p>Male reproductive</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hernia <input type="checkbox"/> Testicular mass <input type="checkbox"/> Testicular pain <input type="checkbox"/> Discharge <input type="checkbox"/> Sores/rashes
<p>Anything else you feel is important to share?</p>	<p>Peripheral circulation</p> <ul style="list-style-type: none"> <input type="checkbox"/> Deep leg pain <input type="checkbox"/> Cold hands/feet <input type="checkbox"/> Varicose veins <input type="checkbox"/> Swollen hands/ankles/feet <input type="checkbox"/> Extremity numbness/coldness <input type="checkbox"/> Extremity ulcers <input type="checkbox"/> Anemia <input type="checkbox"/> Easy bruising 	<p>Musculoskeletal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Joint pain/swelling <input type="checkbox"/> Stiffness <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Muscle pain <input type="checkbox"/> Muscle spasms/cramps <input type="checkbox"/> Back pain <input type="checkbox"/> Broken bones