Ludwig Kragler, L.Ac., M.Ac., Chinese Herbs

Pediatric Intake Form

Child Information: Today's Date: ______________
Name: ____ Sex: M F
Age: _________ Date of Birth: ______________ Height: ___________ Weight: _____________
Grade Level: ____________________
Allergies: ____

Contacts:
1) Name & relation to child: ____
Phone (Cell): ______________________________ (Home): ______________________________
(Work): ________________________________ Address: _________________________________
____
2) Name & relation to child: ____
Phone (Cell): ______________________________ (Home): ______________________________
(Work): ________________________________ Address: _________________________________
____
Who does the child live with? ____

Child's Other Healthcare Providers:
Pediatrician/Family Physician: ____
Phone: __________________________________ Address: ________________________________
____
Other Provider: ____
Phone: __________________________________ Address: ________________________________
____
Other Provider: ____
Phone: __________________________________ Address: ________________________________
____

Health Concerns:
Primary Health Concern: ____
____
Prior Treatments/Medications/Results: ____
____
____
Other Concerns (Please number in order of importance): ___________________________
____
____
Prior Treatments/Medications/Results: ____
____
____

Parents' health AT time of conception (cold, flu, disease, chronic, acute, emotional):

Father: ____
____
____
____

Prescribed medications/Herbs/Supplements/Recreational Drug/Alcohol Use: ______
____
____

Mother: ____
____
____
____

Prescribed medications/Herbs/Supplements/Recreational Drug/Alcohol Use: ______
____
____

Previous pregnancies/births/miscarriages/abortions: ______________________________
____
____
____

Prenatal Health & History:

Mother's health during pregnancy (Wellness, complications, nausea, vaginal bleeding, diabetes, HBP, Physical/Emotional trauma, etc. ?): __________________________
____
____
____
____
____

Mother's Diet (specific examples of meals and foods): ______________________________
____
____
____

Medications/Supplements/caffeine/cigarettes/recreational drugs/alcohol (how much, how often): ____
____
____
____

Birth History:

Mother's age at child's birth: _________________ Term Length: _________________ weeks

Location of birth (circle one): Home Birth Center Hospital Other

Complications during birth (breech, etc.): ____
____

Type of birth (Vaginal, C-Section, Epidural, etc.): ___________________________________
____

Length of labor: ______________________ Infant birth weight: ___________________________

Did child experience any of the following at or shortly after birth (circle)?
Jaundice Rashes Seizures Birth Defects Colic
Birth Injuries: ____
Infections: ____
Feeding difficulties: ____
Other: ____

Dietary History:
Breast Milk: From birth till ______months Formula: from ______months till ________
Other: ____
Did baby experience any reactions to either of these? ____________________________
____
Foods introduced prior to 6 months (what, when, and any reactions to): ____________
____
____
____
Food Allergies (Please list them): ____
____
____
Dietary restrictions for child (what & why): ____________________________________
____
____
____
Please fill out weekly dietary intake form (please be very detailed).

Medical History:
Vaccinations (please list which vaccinations, when, and any reactions or different behavior afterwards): ____
____
____
____
____
____
____
Illnesses up till Age 1 (list when, what diagnosis, symptoms, and treatments): ______
____
____
____
____
____
____
Illnesses from Age 1 and on (list when, what, symptoms, and treatments): __________
____
____
____
____

Re-occurring illnesses: ____

Hospitalizations (when, how long, and for what): ____

Current medications or supplements: ____

Known drug medication allergies: ____

Other allergies: ____

Digestion:

Any bloating, distension, or gas(either right after meal or throughout day)? ____

Regurgitating of food after meals (either immediately or even 1 hour after)? ____

Crying after meals? ____ Crying at night? ____

Bowel Movements:

How often per day: ____ Formed, loose, or both? ____

Hard, soft, or both? ____ Which more often? ____

Any blood with stool? ____ Any undigested food? ____

Any redness around the anus? ____

Urination:

Does the diaper fill with urine? ____ Daily? ____

Any dark yellow or brown colored urine? ____ Blood? ____

Pain with urination? ____

Social Patterns:

Is child active (moving around) or passive (sits around)? ____

Does child engage with peers? ____Does child engage with adults? ____

Does child keep to self? ____ Is child predominantly talkative or quiet? ____

Child in home care, day care, home schooled, or public/private school? ____

Child's behavior at school or daycare (as told to you by teacher or facility): __________
____

Your observation of child's behavior at daycare/school: ____________________________
____

Your observation of child's behavior at home: ____________________________________
____

What kind of physical exercise does the child do (how often and how much)? _______
____

Environment:

Pets at home (what kind, name, age): ______________________________________
____

Anyone in the child's household smoke? Yes No

Type of heating in the home: ____

Is the house cluttered or clean? ____

Family History:

Current illnesses (chronic, acute, mental, physical) with the Father: _________________
____
____
____
____
____

Current illnesses (chronic, acute, mental, physical) with the Mother: ________________
____
____
____
____
____

Current illnesses (chronic, acute, mental/behavioral, physical) with Siblings: _______
____
____
____
____

Anything you feel that is important that has not been covered or mentioned? _______
____
____

Weekly Dietary Intake Form

Monday ->				
Tuesday ->				
Wednesday ->				
Thursday ->				
Friday->				
Saturday ->				
Sunday ->				