Dr. Renee Mammone, N.D.
Dr. Marie Mammone, N.D.
Naturopathic Physicians

Naturopathic & Acupuncture Health Center
274 Silas Deane Hwy
Wethersfield, CT 06109

John Mammone, L.Ac.
Licensed Acupuncturist

Pediatric Intake Form

Patient Name: _____DOB:_____

Street Address:_____

City: _____ State: _____ Zip Code: _____ Phone: _____

Sex (m / f) Grade of School: _____email:_____

Mother's Name and Occupation: _____

Father's Name and Occupation: _____

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

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

Regular Pediatrician name and city located in: _____

Last time you had blood work done and with what physician: _____

_____

How did you hear about me?_____

Reason for Office Visit::_____

_____

List All Surgeries & Hospitalizations, including date occurred:

1) _____4)_____

2) _____5)_____

3)_____ 6)_____

List All medicines (from drugstore or prescription) child is on now:

1) _____4)_____

2) _____5)_____

3)_____ 6)_____

Blood type:_____

List all supplements child is taking:

1) _____4)_____

2) _____5)_____

3)_____ 6)_____

Any known Allergies to food, drugs, environment, animals:_____

_____

Previous Medical History

YES (Y) indicates the child gets the problem regularly; **NO (N)** indicates the child never had the problem; **PAST (P)** indicates the child had the problem in the past, but not recently. **Please circle the correct one for your child.**

Ear Infections: Y N P If has had, how many total:_____

Colds: Y N P If has had, how many total:_____

Strep Throat: Y N P 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) _____3)_____

2) _____4)_____

Hearing Tests Normal: Yes No Not Tested

Vision Tests Normal: Yes No Not Tested

Speech Impediments: Yes No Past

Learning Impediments: Yes No Past

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 Polio: Yes No Some

Hib: Yes No Some Chicken Pox: Yes No Some

Other:

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

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Family History

Allergies: Y N P Obesity: Y N P

Cancer: Y N P Tuberculosis: Y N P

Mental Illness: Y N P Cardiovascular Disease: Y N P

Diabetes mellitus: Y N P

Mother's Pregnancy History

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

Health During Pregnancy

Smoking: Y N Diabetes: Y N Coffee: Y N Nausea/Vomiting: Y N

Recreational Drugs: Y N Emotional Stress: Y N

Preeclampsia: Y N Length of Labor:_____ Vaginal Birth: Y N

Traumatic Birth: Y N If the birth was difficult, please explain:_____

_____

Health of baby at birth:_____

Health History of Child

Child Breastfed: Y N 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:_____

Jaundice as baby:	Y N	Colic :	Y N
Cradle Cap:	Y N	Anemia:	Y N
Eczema or Psoriasis:	Y N	Asthma:	Y N
Diarrhea:	Y N	Warts:	Y N
Constipation:	Y N	Nightmares:	Y N
Finicky Eating:	Y N	Bed-wetting:	Y N
Poor Teeth:	Y N	Tantrums:	Y N
Chronic Sniffles:	Y N	Disobedient:	Y N
Bad Foot Odor:	Y N	Fears/Phobia:	Y N
Very Sweaty: Baby/Child:	Y N	Diaper Rash:	Y N
Hyperactivity:	Y N	Early Puberty:	Y N
Growing Pains:	Y N	Stomach Aches:	Y N

Any Particular household stressors child has witnessed or gone through:

1) _____3)_____

2) _____4)_____

Toxin Exposure

Has the child ever lived near a refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to?_____

_____

Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health at all?_____

_____

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

_____

Do you spray pesticides, herbicides or other chemicals around your home?_____

_____

Typical Day's Diet

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

_____