ELIXIR
A WELLNESS COLLECTIVE

2146 NE 4TH STREET #160 BEND, OR 97701
541-306-4471 PHONE | 541-566-7493 FAX
HELLO@ELIXIRBEND.COM
ELIXIRBEND.COM

PEDIATRIC INTAKE FORM

Patient Name:_____ Today's Date:___/___/_____

Date of Birth:_____ Age:_____ Place of Birth:_____

Address:_____ City/State/Zip:_____

Email address:_____
We respect your privacy. We will only use your email to contact you about patient-related issues.

Guardian Name:_____ Phone:_____Relationship:_____

How did you hear about our clinic? _____

What do you know about our approach to health and healing? _____
_____

What expectations/goals do you have from this visit? _____
_____

What is your present level of commitment to addressing underlying causes and making changes in your child's lifestyle? (1-10 scale, 10 being the highest) _____

Gender: **Male / Female / Other**

Mother's Name and Occupation:

Father's Name and Occupation:

Parents are (Circle one): **Married Separated Divorced Living Together Other**: _____

Reason for Office visit:

Concern Ex: Fever	*Since Ex: Last 2 Months*	*Frequency Ex: Daily*	*Severity 1-10 (10 worst)*
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____

Has the child seen any other doctor(s) for this complaint? **Y N P**

Pediatrician's name: Phone Number:

Address:

Last date you had blood work done: _____
Blood work done with what doctor? _____

List all surgeries and hospitalizations and date occurred:
1._____
2._____

Is the child allergic to any medicines? **Y N** If yes, please list them: _____
Is the child allergic to any foods? **Y N** If yes, please list them: _____

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List all medicines child is taking (prescription or from drugstore)

Name	*Dosage Ex:300mg*	*Times taken/day*	*How Long Taken Ex:1year*
1.			
2.			
3.			

List all supplements child is taking:

Name	*Dosage Ex:300mg*	*Times taken/day*	*How Long Taken Ex:1year*
1.			
2.			
3.			

Past medical history:
Yes (Y) indicates the child gets the problem regularly**; No (N)** indicates the child never has the problem**; Past (P)** indicates the child had the problem in the **past, but not recently. Circle the correct one for your child.**

Ear Infections: **Y N P** If yes, how many total: _____
Colds: **Y N P** If yes, how many total: _____
Strep Throat: **Y N P** If yes, how many total: _____

Approximately how many rounds of antibiotics has the child taken TOTAL?
☐0 ☐1-5 ☐6-10 ☐11-15 ☐16-20 ☐20 or more

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 (Y); No (N); Some (S) did not finish all shots.

MMR:	**Y N S**	DPT:	**Y N S**	Hep B:	**Y N S**
Hib:	**Y N S**	PCV:	**Y N S**	Polio:	**Y N S**

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

Family history: Circle **G**randparent **P**arent or **S**ibling

Cancer	**G P S**	Diabetes	**G P S**	Allergies	**G P S**
Heart Disease	**G P S**	Autoimmune Disease	**G P S**	Obesity	**G P S**
Lung Disease	**G P S**	Mental Illness	**G P S**	Thyroid Illness	**G P S**

Other: _____

Mother's Pregnancy History:
Age at conception: _____ Did she have other children already? _____

Smoking:	**Y N**	Diabetes:	**Y N**	Coffee:	**Y N**
Recreational Drugs:	**Y N**	Emotional Stress**:**	**Y N**	Nausea/Vomiting:	**Y N**
Preeclampsia:	**Y N**	Length of Labor: _____		Vaginal Birth:	**Y N**
Traumatic Birth: **Y N**		If birth was difficult please explain: _____			

_____

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Health History of Child:

Health of baby at birth: _____

Child Breastfed: **Y N** For how long:_____ If put on formula, at what age?:_____

What formula was used: _____ At what age was child put on solid food: ____

At what age 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:	**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 the child has witnessed or gone through?

1._____

2._____

Toxin Exposure:

Has the child ever lived near a refinery, polluted area or in a home with lead 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? _____

Diet: *Please list what your child had yesterday for:*

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the doctor's office of any changes in my child's health status. I also authorize the healthcare staff to perform the necessary health care services my child may need.

_____ _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN **DATE**

_____ _____

GUARDIAN NAME **RELATIONSHIP TO PATIENT**