GOODE INTEGRATIVE HEALTH CARE

PEDIATRIC PATIENT INTAKE

Name:_____ Date of Birth:_____

Mother's Name:_____ Father's Name:_____

Address: _____

City: _____ State:_____ Zipcode:_____

Home Phone Number:_____

Number of Siblings:_____ Birth Weight: _____ Birth Length:_____ Current Weight:_____

Purpose of Today's Visit:_____

Type of Birth: ___ Normal Vaginal ___Forceps ___Breech ___C-Section ___Home

Place of Birth: ___ Home ___ Birth Center ___ Hospital

Problems During Pregnancy: _____

Problems During Labor/Delivery: _____
_____

Medications Given During Labor/Delivery: _____

Infant Feeding: ___ Breast ___ Bottle ___ Formula

Number of Hours Sleeping at Night: ___ _ Quality of Sleep: ___Good ___Fair ___Poor

Obstetrician/Midwife:_____ Pediatrician/Family Doctor:_____

Last Visit to Doctor:_____ Purpose:_____

Choose to Immunize:____ Yes ___No

Has/Does this Child Suffer From:

___Poor Appetite ___ Bed Wetting ___ Neck Problems ___Backaches ___Tuberculosis

___Headaches ___Hyperactivity ___Digestive Disorders ___Walking Problems ___Asthma

___Sinus Trouble ___Stomach Aches ___Chronic Ear Aches ___Constipation ___Diarrhea

___Behavioral Problems ___Ruptures/Hernia ___"Growing Pains" Other:_____

Has your child ever been treated on an Emergency basis? Please describe:_____

_____

Surgery:_____
Medications:_____

Accidents:_____

Family History:_____

Authorization for Care of Minor

I hereby authorize Goode Integrative Health Care and its doctors to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian)

Date:_____

Signature:_____

Witness:_____