Anita M. Larrow, ND
Bringing Naturopathic Medicine to your door
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Pediatric Initial Intake:

The Initial Intake includes comprehensive consultation time with the doctor, a review of systems and the follow physical exams: Respiratory, Cardiac, Head, Ears, Nose, Eyes, Throat, Neurological and Abdominal. Other physical exams maybe done as your child's case needs. Lab testing is an important part of diagnosis; we ask that you have your child's recent blood work available for Dr. Larrow. If you do not have recent lab work, which is fine Dr. Larrow will recommend blood work as needed to complete your child's case history. Labs will be billed separately and in accordance to your insurance, if applicable.

Personal Information:

Name:		
Today's Date (mm/dd/yy): / /	Age:	Birth date (mm/dd/yy): / /
Sex:	Parents living under same roof as child: ☐ yes ☐ no	
Mother's Name:		
Mother's phone number:		
Father's Name:		
Father's Phone number:		
Email:		

Home Address:_____
Street City State Zip Code

In case of emergency, please contact:_____ _____ _____
(name) (phone) (relationship)

1. Describe your condition _____

_____

_____

When did it start? _____ Has this condition been diagnosed? □ yes □ no

Diagnosis _____

Are you currently receiving any treatment for this condition? *Please describe*: _____

_____

2. Describe your condition _____

_____

_____

When did it start? _____ Has this condition been diagnosed? □ yes □ no

Diagnosis _____

Are you currently receiving any treatment for this condition? *Please describe*: _____

_____

3. Describe your condition _____

_____

_____

When did it start? _____ Has this condition been diagnosed? □ yes □ no

Diagnosis _____

Are you currently receiving any treatment for this condition? *Please describe*: _____

_____

What would you most like to accomplish on your first visit? _____

_____

Healthcare History and Providers Information

Pediatrician's/Primary Care's Contact Information:

_____

Is Child still currently seeing Pediatrician (please circle)? Y N

If No, will Dr. Anita Larrow be acting as the child's primary care (please circle): Y N

When was the child's last visit to the doctor? _____

What was the reason? _____

_____

Has or is the child currently seeing (a) medical specialist (s)? Y N

If yes, for what reason? _____

_____

Name and contact information for the medical specialist (s):_____

_____

Pregnancy Information (for mother):

Name of Obstetrician/Midwife/Doula/Pregnancy Coach: _____

How would you describe your labor experience? _____

_____

How many hours in labor:_____ Place of Child's Birth: _____

During your pregnancy with this child, did you:

1. Have high blood pressure?	Y	N
2. Have diabetes or sugar in your urine?	Y	N
3. Have German (3 day) Measles?	Y	N
4. Take any medicines?	Y	N
5. Smoke cigarettes?	Y	N
6. Get treatment for gonorrhea or syphilis?	Y	N
7. Test positive for vaginal Group B Strep?	Y	N
8. Drink alcohol?	Y	N
9. Use other drugs?	Y	N
10. Have this child early (premature)?	Y	N
11. Have more than one baby delivered?	Y	N
12. Have a difficult labor and / or delivery?	Y	N
13. Was it a breech (bottom first) delivery?	Y	N
14. Was it a Cesarean delivery?	Y	N

15. What was your due date?_____
16. How early did you start seeing a doctor? _____
17. What is the mother's blood type? _____
18. What is the baby's blood type? _____

Child's Past / Present Medical / Nutritional History

1. Baby's birth weight	_____lbs	___oz
2. Did your baby breathe / cry immediately at birth?	Y	N
3. Was the baby jaundiced at birth	Y	N
4. Did the baby have an RH problem?	Y	N
Receive blood?	Y	N
5. At birth, did the baby appear normal?	Y	N
6. Was PKU testing done at birth?	Y	N
7. During baby's FIRST year, did you breast feed?	Y	N
How long?_____		
8. During baby's FIRST year, did you formula feed?	Y	N
How long? _____		

9. If feeding problem, explain:_____
10. Weaning from breast completed at age:_____
11. Solid food started at age: _____

Problems/Allergies/Sensitivities when starting food? _____

_____

Past Medical History

Hospitalizations/Surgeries: give description & date of any serious illnesses or operations:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

What is your child's blood type, if you know?

Please note when and why your child had each of the following:

X-Rays: _____
MRI/Cat Scans: _____
Ultrasounds:_____
Accidents:_____
TB Test: _____
HCV:_____
HIV: _____
Last Dental Visit: _____
Last Eye Exam: _____

Vaccinations

Has your child received all of their vaccinations up to their age? □ Yes □ No

If yes, which did your child receive?

□ Polio □ Rubella □ Flu Vaccine □ Tetanus □ Measles □ Diphtheria

□ Smallpox □ Mumps □ Hepatitis B □ Pertussis □ Other: _____

What vaccinations is your child behind on (if any)?_____

_____

Have your child received the vaccination for chicken pox? □ Yes □ No

Have your child received any vaccinations for travel? □ Yes □ No

If yes, which vaccinations _____

Family History (Circle "Y" for Yes, "N" for No and "DK" for Don't Know)

	Father	Mother	Sibling	Sibling	Sibling	Sibling
Age if living:	_____	_____	_____	_____	_____	_____
Age when died:	_____	_____	_____	_____	_____	_____
Cause of death:	_____	_____	_____	_____	_____	_____
CANCER TYPE (if had):	_____	_____	_____	_____	_____	_____
High Blood Pressure:	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK
Heart Attack/Stroke:	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK
Heart Disease:	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK
Asthma/Allergies:	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK
Mental Illness:	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK
Thyroid:	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK
Auto-Immune Disease:	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK
Diabetes type 1 or 2:	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK
Osteoporosis:	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK
Arthritis:	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK	Y N DK

	Grandmother Mother's Side	Grandfather Mother's Side	Grandmother Father's Side	Grandfather Father's Side
Age if living:	_____	_____	_____	_____
Age when died:	_____	_____	_____	_____
Cause of death:	_____	_____	_____	_____
CANCER TYPE (if had):	_____	_____	_____	_____
High Blood Pressure:	Y N DK	Y N DK	Y N DK	Y N DK
Heart Attack/Stroke:	Y N DK	Y N DK	Y N DK	Y N DK
Heart Disease:	Y N DK	Y N DK	Y N DK	Y N DK
Asthma/Allergies:	Y N DK	Y N DK	Y N DK	Y N DK
Mental Illness:	Y N DK	Y N DK	Y N DK	Y N DK
TB:	Y N DK	Y N DK	Y N DK	Y N DK
Auto-Immune Disease:	Y N DK	Y N DK	Y N DK	Y N DK
Diabetes type 1 or 2:	Y N DK	Y N DK	Y N DK	Y N DK
Osteoporosis:	Y N DK	Y N DK	Y N DK	Y N DK
Arthritis:	Y N DK	Y N DK	Y N DK	Y N DK
Thyroid:	Y N DK	Y N DK	Y N DK	Y N DK

Social Life

Child has how many siblings? **Sisters?** _____ **Brothers?**_____
Child is Oldest / Youngest / Middle in family (circle one)?
Other children's ages _____ / _____ / _____ / _____/ _____ / _____

Who spends the most time caring for child? _____

Does child go to day care, baby-sitter or school on a regular basis? Y N
If school age, what grade in school: _____
How is the child doing in school? _____

Are there any pets in the home? Y N **Number**_____ **Type**_____

Child sat up at age: _____ **Child crawled at age:** _____
Child walked at age:_____ **Child started talking at age:** _____

Any Smokers in the home? Y N

Sleep

How many hours per night? _____ **If your child wakes up frequently, why**? _____

_____

What Time does your child typically go to bed? _____

What time does your child typically rise from bed?_____

Nightmares: Y N P **Wake Refreshed**: Y N P **Must nap during the day**: Y N P

Sleep walk: Y N P **Grind teeth**: Y N P **Snore**: Y N P

Typical Day's Diet

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Fluids: _____

Toxin Exposure

Did you live near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to?

_____

Do the parents have any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? _____

_____

Is your child particularly sensitive to perfumes, gasoline or other vapors? _____

Do you use pesticides, herbicides or other chemicals around your home? Please list if you can _____

_____

_____

Pharmaceuticals:

Please list ***all*** the medications you are currently taking:

Medication	Dosage	Time Taken

Who prescribed them?

Botanicals/Homeopathics/Vitamins:

Please list any Herbs / Vitamins / Homeopathics / other supplements you are currently taking, including brand, dosage and length of time taken:

Name	Dosage	Length of Time Taken

Allergic Reactions

Please name any foods, plants or vitamins to which you have had allergic reactions:

Have you ever had any allergic reactions to the following:

Codeine, novocaine? (Y/N)	Sulfa drugs? (Y/N)
Penicillin or other antibiotics? (Y/N)	Sedatives? (Y/N)
Anti-coagulants (Coumadin)? (Y/N)	Iodine? (Y/N)
Barbiturates (sleeping pills)? (Y/N)	Aspirin? (Y/N)

Other:

Review of Systems:

Present Weight: _____lbs__**Weight one month ago**:_____ lbs__**Weight one year ago**:__ ____ lbs__

Height: _____ft_____in__

REGARDING THE NEXT LONG SECTION: Please circle or highlight (**Y)** if you have the problem **NOW**, (**N)** if you've **NEVER** had the problem, (**P)** if you had the problem in the **PAST**.

SKIN				
Rash:	Y N P		**Color Change:**	Y N P
Hives:	Y N P		**Lump:**	Y N P
Psoriasis/eczema:	Y N P		**Itchy:**	Y N P
Dry:	Y N P		**Warts/moles:**	Y N P
HEAD				
Headache:	Y N P		**Migraine:**	Y N P
Dandruff:	Y N P		**Head Injury:**	Y N P
EYES				
Dry/Watery:	Y N P		**Blurry Vision:**	Y N P
Double Vision:	Y N P		**Styes:**	Y N P
Strain	Y N P		**Discharge:**	Y N P
Itchy:	Y N P		**Dark Under Eyelid:**	Y N P

EARS				
Diminished Hearing:	Y N P		**Ringing in Ears:**	Y N P
Infections:	Y N P		**Pain:**	Y N P
NOSE				
Frequent Colds:	Y N P		**Nosebleeds:**	Y N P
Congestion:	Y N P		**Seasonal Allergies:**	Y N P
MOUTH/THROAT				
Canker Sores:	Y N P		**Cold Sores:**	Y N P
Sore Throat:	Y N P		**Gum Disease/cavities:**	Y N P
NECK				
Stiffness:	Y N P		**Swollen Glands:**	Y N P
Full movement:	Y N P		**Tension:**	Y N P

RESPIRATORY				
Cough:	Y N P		**TB:**	Y N P
Shortness of breath w/ exertion:	Y N P		**Bronchitis:**	Y N P
Shortness of breath sitting:	Y N P		**Pneumonia:**	Y N P
Shortness of breath lying down:	Y N P		**Asthma:**	Y N P
Wheezing:	Y N P		**Painful breathing:**	Y N P
CARDIOVASCULAR				
High Blood Pressure:	Y N P		**Rheumatic Fever:**	Y N P
Low Blood Pressure	Y N P		**Murmurs:**	Y N P
Arrhythmias:	Y N P		**Palpitations:**	Y N P
Edema:	Y N P		**Chest Pain:**	Y N P
GASTROINTESTINAL				
Heartburn:	Y N P		**Bowel Movement Freq:**	(Number of times per day every week)
Bloating:	Y N P		**Recent BM Change:**	Y N P
Nausea:	Y N P		**Diarrhea/Constipation:**	Y N P
Vomiting:	Y N P		**Change in Appetite:**	Y N P
URINARY TRACT				
Frequent Infections:	Y N P		**Pain w/ Urination**	Y N P
Urgency:	Y N P		**Discharge/Blood:**	Y N P

Anything Else I should know?_____

_____

_____

How Did You Hear About Dr. Larrow? Referral from:_____, Internet