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Orna Izakson, ND, RH (AHG)
4921 NE 28th Ave., Portland, OR 97211
503.335.9479v • 503.575.9229f
dro@celilohealth.com

PEDIATRIC INTAKE FORM (6 TO 12 YEARS)

Patient's Name: _____ Date: _____

Date of birth: _____ Age: _____ Gender: _____

Parent/Guardian's Name: _____ Insurance Plan:_____

Address: _____

City: _____ State: _____ Zip: _____

Telephone (home): _____ (Parent's work):_____

Parent's email address: _____

How did you hear about this clinic? _____

If Internet: Google: _____ AHG: ____ AANP: ____ OANP: ____ Other website: _____

Has any other family member already been a patient at this clinic?_____

Name of doctor's office/hospital/clinic where your child's health records are kept:_____

_____

Reason for referral or presenting problems: _____

_____

HEALTH HISTORY QUESTIONNAIRE

Birth city & state: _____ Birth time: _____ Birth weight:_____

What are your child's most important health problems? List as many as you can in order of importance:

1._____

2._____

3. _____

4. _____

5. _____

Does your child have a contagious disease at this time? Y☐ N☐

If yes, what? _____

CELILO NATURAL HEALTH CENTER LLC

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MEDICAL HISTORY

☐ Chicken pox ☐ Scarlet fever ☐ Tonsillitis, approx no. of times: _____
☐ Measles ☐ Pneumonia ☐ Ear infections, approx no. of times: _____
☐ Mumps ☐ Frequent colds ☐ Strep throat, approx no. of times: _____
☐ Rubella ☐ Rheumatic fever ☐ Other: _____

Has your child ever had any of the following? WHEN WHERE RESULTS

Electroencephalogram (EEG): _____

Psychological evaluations:_____

Hearing test: _____

Vision test: _____

Speech/language tests: _____

Injuries/surgeries/hospitalizations (please list): _____

_____

VACCINATIONS

☐ Measles/Mumps/Rubella ☐ Polio ☐ Smallpox ☐ Influenza
☐ Diptheria/Pertussis/Tetanus ☐ Haemophilus influenza (Hib) ☐ Chicken pox

Others:_____

Adverse reactions: Y ☐ N ☐ If so, what? _____

ALLERGIES

Is you child hypersensitive or allergic to

Any drugs?_____

Any foods? _____

Any environmentals?_____

Breast fed: Y/N How long: _____ Formula: Y/N Type (milk, soy):_____

Age began solids: _____ Which foods:_____

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TYPICAL FOOD INTAKE

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

Please list any prescription medications, over the counter medications, vitamins or other supplements your child is taking:

Is there any information about your child's health that you would like to add?

What expectations do you have for your child from working with our clinic?

Welcome! We're honored to be of service to you and your child!

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REVIEW OF SYSTEMS

Y = a condition now P = significant problem in the past N = never had

MENTAL/EMOTIONAL
Mood Swings Y O P O N O
Irritability Y O P O N O
Hyperactivity Y O P O N O
Introvert/extrovert Y O P O N O
Motion/car sickness Y O P O N O
Anxiety/nervousness Y O P O N O
Cries easily Y O P O N O
Unusual fears Y O P O N O
Sleep problems Y O P O N O
Nightmares Y O P O N O

ENDOCRINE
Heat/cold intolerance Y O P O N O
Fatigue Y O P O N O
Excessive thirst Y O P O N O
Excessive hunger Y O P O N O
No appetite Y O P O N O
Low blood sugar Y O P O N O
High blood sugar Y O P O N O

IMMUNE
Night sweats Y O P O N O
High fevers Y O P O N O

SKIN
Rashes Y O P O N O
Eczema, Hives Y O P O N O
Acne, Boils Y O P O N O
Itching Y O P O N O
Body odor Y O P O N O

HEAD
Headaches Y O P O N O
Head Injury Y O P O N O
Dizzy spells Y O P O N O
High fevers Y O P O N O
Hair loss Y O P O N O

EYES
Glasses or contacts Y O P O N O
Tearing or dryness Y O P O N O
Eye pain/strain Y O P O N O

EARS
Earaches Y O P O N O
Impaired hearing Y O P O N O

NOSE AND SINUSES
Frequent colds Y O P O N O
Nose Bleeds Y O P O N O
Stuffiness Y O P O N O
Hayfever Y O P O N O
Sinus problems Y O P O N O
Loss of smell Y O P O N O

MOUTH AND THROAT
Frequent sore throat Y O P O N O
Canker sores Y O P O N O
Breath odor Y O P O N O
Bleeding gums Y O P O N O

RESPIRATORY
Cough Y O P O N O
Wheezing Y O P O N O
Asthma Y O P O N O
Bronchitis Y O P O N O

CARDIOVASCULAR
Heart disease Y O P O N O
Murmurs Y O P O N O

URINARY
Frequent urination Y O P O N O
Bed wetting Y O P O N O
Burning urine Y O P O N O

GASTROINTESTINAL
Belching/passing gas Y O P O N O
Stomach aches Y O P O N O
Vomiting spells Y O P O N O
Constipation Y O P O N O
Diarrhea Y O P O N O
Bowel Movement frequency: _____

MUSCULOSKELETAL
Joint pain/stiffness Y O P O N O
Muscle spasms/cramps Y O P O N O
Broken bones Y O P O N O

BLOOD/PERIPHERAL VASCULAR
Anemia Y O P O N O
Easy bleeding/bruising Y O P O N O