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## PEDIATRIC INTAKE FORM (BIRTH TO 5 YEARS)

PATIENT'S NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ GENDER: M / F

PARENT/GUARDIAN'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PARENT'S E-MAIL: \_\_\_\_\_

PHONE: (HOME) \_\_\_\_\_ (CELL) \_\_\_\_\_ (WORK) \_\_\_\_\_

IS IT OK TO CALL AND LEAVE A MESSAGE AT HOME? Y N ON YOUR CELL? Y N AT WORK? Y N

DOCTOR'S OFFICE/HOSPITAL/CLINIC WHERE YOUR CHILD'S HEALTH RECORDS ARE KEPT \_\_\_\_\_

HAS ANY FAMILY MEMBER BEEN A PATIENT AT OUR CLINIC? Y N IF YES, WHO? \_\_\_\_\_

HOW DID YOU HEAR ABOUT SWEETGRASS NATURAL MEDICINE? \_\_\_\_\_

REASON FOR TODAY'S VISIT OR CHIEF COMPLAINT? \_\_\_\_\_

### MEDICATIONS

NOW	PAST	NOW	PAST
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___

ALLERGIES TO MEDICINES: \_\_\_\_\_

### MEDICAL HISTORY

___	___	___
___	___	___
___	___	___
___	___	___
___	___	___

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING? WHEN WHERE RESULTS

ELECTROENCEPHALOGRAM (EEG): \_\_\_\_\_

HEARING TESTS: \_\_\_\_\_

SPEECH/LANGUAGE TESTS: \_\_\_\_\_

PSYCHOLOGICAL EVALUATION: \_\_\_\_\_

INJURIES/SURGERIES/HOSPITALIZATIONS (PLEASE LIST) \_\_\_\_\_

**IMMUNIZATIONS**

\_\_\_ MMR                      \_\_\_ DPT                      \_\_\_ CHICKEN POX                      OTHERS: \_\_\_\_\_  
\_\_\_ MEASLES                      \_\_\_ DIPHTHERIA                      \_\_\_ SMALL POX  
\_\_\_ MUMPS                      \_\_\_ TETANUS                      \_\_\_ H. INFLUENZA                      ADVERSE REACTIONS? Y      N  
\_\_\_ RUBELLA                      \_\_\_ POLIO                      \_\_\_ THE FLU                      PLEASE DESCRIBE: \_\_\_\_\_

**FAMILY HISTORY**

\_\_\_ HEART DISEASE                      \_\_\_ DIABETES                      \_\_\_ BIRTH DEFECTS  
\_\_\_ HYPERTENSION                      \_\_\_ ARTHRITIS                      \_\_\_ TUBERCULOSIS  
\_\_\_ CANCER                      \_\_\_ ALLERGIES                      \_\_\_ MENTAL ILLNESS

**PRENATAL HISTORY**

PREVIOUS PREGNANCIES BY NATURAL MOTHER, MISCARRIAGES, OR COMPLICATIONS?

MOTHER'S AGE AT CHILD'S BIRTH? \_\_\_\_\_

MOTHER'S HEALTH DURING PREGNANCY?

\_\_\_ BLEEDING                      \_\_\_ PHYSICAL OR EMOTIONAL TRAUMA  
\_\_\_ NAUSEA                      \_\_\_ CIGARETTES, ALCOHOL, DRUG CONSUMPTION  
\_\_\_ ILLNESSES                      \_\_\_ MEDICATIONS  
\_\_\_ HYPERTENSION                      \_\_\_ THYROID PROBLEMS                      \_\_\_ DIABETES

**BIRTH HISTORY**

TERM: FULL \_\_\_\_\_ PREMATURE \_\_\_\_\_ LATE \_\_\_\_\_ WEIGHT AT BIRTH \_\_\_\_\_

LENGTH OF LABOR \_\_\_\_\_ COMPLICATIONS? \_\_\_\_\_

DID YOUR CHILD HAVE ANY OF THE FOLLOWING PROBLEMS SHORTLY AFTER BIRTH?

\_\_\_ BIRTH DEFECTS                      \_\_\_ BIRTH INJURIES                      \_\_\_ BLUE BABY  
\_\_\_ CEREBRAL PALSY                      \_\_\_ SEIZURES                      \_\_\_ JAUNDICE  
\_\_\_ COLIC                      \_\_\_ FEVER                      \_\_\_ RASHES

OTHER: \_\_\_\_\_

CHILD'S SLEEP PATTERNS (1ST YEAR) \_\_\_\_\_

FOOD INTOLERANCES (IF ANY) \_\_\_\_\_

FEEDING: BREAST FED? Y N      HOW LONG? \_\_\_\_\_ FORMULA? Y N      MILK / SOY \_\_\_\_\_

AGE BEGAN SOLIDS \_\_\_\_\_ WHICH FOODS? \_\_\_\_\_

AGE BEGAN: SITTING \_\_\_\_\_ CRAWLING \_\_\_\_\_ WALKING \_\_\_\_\_ TALKING \_\_\_\_\_

**SYMPTOMS** (MARK **Y** IF CURRENT, **P** FOR PAST SYMPTOMS, LEAVE BLANK IF NEVER)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> HIVES          | <input type="checkbox"/> BURNING OF URINE   | <input type="checkbox"/> BLOODY URINE        |
| <input type="checkbox"/> ECZEMA         | <input type="checkbox"/> FREQUENT URINATION | <input type="checkbox"/> CRIES EASILY        |
| <input type="checkbox"/> BLEEDING GUMS  | <input type="checkbox"/> HEART MURMUR       | <input type="checkbox"/> NERVOUS             |
| <input type="checkbox"/> NOSE BLEEDS    | <input type="checkbox"/> VOMITING SPELLS    | <input type="checkbox"/> SLEEP PROBLEMS      |
| <input type="checkbox"/> ACNE           | <input type="checkbox"/> ANEMIA             | <input type="checkbox"/> NIGHT SWEATS        |
| <input type="checkbox"/> HIGH FEVERS    | <input type="checkbox"/> STOMACH ACHES      | <input type="checkbox"/> SENSITIVE TO LIGHT  |
| <input type="checkbox"/> CHRONIC RASH   | <input type="checkbox"/> JAUNDICE           | <input type="checkbox"/> BODY/BREATH ODOR    |
| <input type="checkbox"/> HEARING LOSS   | <input type="checkbox"/> EASY BRUISING      | <input type="checkbox"/> MOTION/CAR SICKNESS |
| <input type="checkbox"/> DIARRHEA       | <input type="checkbox"/> FLAT FEET          | <input type="checkbox"/> NO APPETITE         |
| <input type="checkbox"/> SORE THROATS   | <input type="checkbox"/> CONSTIPATION       | <input type="checkbox"/> NIGHTMARES          |
| <input type="checkbox"/> HEADACHES      | <input type="checkbox"/> GAS                | <input type="checkbox"/> CANKER SORES        |
| <input type="checkbox"/> FREQUENT COLDS | <input type="checkbox"/> BLEEDING TENDENCY  | <input type="checkbox"/> UNUSUAL FEARS       |
| <input type="checkbox"/> WHEEZING       | <input type="checkbox"/> JOINT PAINS        | <input type="checkbox"/> EXCESSIVE FATIGUE   |
| <input type="checkbox"/> COUGH          | <input type="checkbox"/> DIZZY SPELLS       | <input type="checkbox"/> HAIR LOSS           |

**DIET**

PLEASE DESCRIBE YOUR CHILD'S TYPICAL DAILY DIET:

BREAKFAST: \_\_\_\_\_

LUNCH: \_\_\_\_\_

DINNER: \_\_\_\_\_

SNACKS: \_\_\_\_\_

TO DRINK: \_\_\_\_\_

**OTHER CONCERNS:**

THANK YOU. WE LOOK FORWARD TO HELPING YOUR CHILD IN ANY WAY WE CAN.