



**Orna Izakson, ND, RH (AHG)**  
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### 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: \_\_\_\_\_

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### 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? \_\_\_\_\_



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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  
 Diphtheria/Pertussis/Tetanus     Haemophilus influenza (Hib)     Chicken pox  
 Others: \_\_\_\_\_  
 Adverse reactions: Y / N    If so, what? \_\_\_\_\_

**ALLERGIES**

Is your child hypersensitive or allergic to

Any drugs? \_\_\_\_\_

Any foods? \_\_\_\_\_

Any environmental? \_\_\_\_\_

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

**ENDOCRINE**

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

**IMMUNE**

Night sweats	Y	P	N
High fevers	Y	P	N

**SKIN**

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

**HEAD**

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

**EYES**

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

**EARS**

Earaches	Y	P	N
Impaired hearing	Y	P	N

**NOSE AND SINUSES**

Frequent colds	Y	P	N
Nose Bleeds	Y	P	N
Stuffiness	Y	P	N
Hayfever	Y	P	N
Sinus problems	Y	P	N
Loss of smell	Y	P	N

**MOUTH AND THROAT**

Frequent sore throat	Y	P	N
Canker sores	Y	P	N
Breath odor	Y	P	N
Bleeding gums	Y	P	N

**RESPIRATORY**

Cough	Y	P	N
Wheezing	Y	P	N
Asthma	Y	P	N
Bronchitis	Y	P	N

**CARDIOVASCULAR**

Heart disease	Y	P	N
Murmurs	Y	P	N

**URINARY**

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

**GASTROINTESTINAL**

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

**MUSCULOSKELETAL**

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

**BLOOD/PERIPHERAL VASCULAR**

Anemia	Y	P	N
Easy bleeding/bruising	Y	P	N