Dr. Amy Hawkins, ND
NATUROPATHIC FAMILY WELLNESS
natural health for the whole family

Thank you for scheduling your child an appointment with Dr. Amy Hawkins, ND.

Please be sure to set aside some time to **complete the following forms and upload them to your child's ChARM portal prior to their first appointment**. If you are unable to scan and upload the forms to the portal, then you can instead fax them to Dr. Hawkins at 910.795.1365. If you are unable to complete this packet prior to your child's first appointment, then we will need to reschedule.

It is extremely helpful to **also upload any recent blood work, imaging results and any applicable assessments or reports to your portal prior to your child's first appointment.** If necessary, you can print the Authorization to Release Medical Information form from the website, fill it out and send it to your other doctors to have records sent directly to my office.

If you are unable to keep your child's scheduled appointment time, please provide me with at least 48 hours notice so that other clients may utilize that appointment time.

Thank you for entrusting me with your child's health. I look forward to meeting you and working together!

Pediatric Client Registration

Pediatric Client Registration

Patient ..... Sex ❑ M ❑ F DOB ..... SS# .....

Mother ..... DOB ..... SS# .....

Address ..... Home # ..... Cell # .....

City/State/Zip ..... Email .....

Employer ..... Work # .....

Father ..... DOB ..... SS# .....

Address ..... Home # ..... Cell # .....

City/State/Zip ..... Email .....

Employer ..... Work # .....

Sibling ..... Sex ❑ M ❑ F DOB ..... SS# .....

Sibling ..... Sex ❑ M ❑ F DOB ..... SS# .....

Sibling ..... Sex ❑ M ❑ F DOB ..... SS# .....

Children live with: ❑ M ❑ F ❑ Guardian ❑ Grandparents ❑ Other .....

Emergency Contact ..... Relation ..... Phone # .....

Party responsible for Payment of Medical Services ❑ M ❑ F ❑ Guardian ❑ Grandparents ❑ Other .....

How did you hear about our practice? .....

Insurance Information

Primary ..... Claim Address .....

Policy # ..... Group# ..... Co-pay .....

Secondary ..... Claim Address .....

Policy # ..... Group# ..... Co-pay .....

Name of Insured ..... DOB ..... Relation .....

Primary Care Physician ..... Phone # ..... City .....

Dr. Amy Hawkins, ND

Naturopathic Family Wellness

PEDIATRIC INTAKE FORM

CLIENT INFORMATION

Name_____Date of 1st Visit _____

Date of Birth_____Age_____Gender: M F

HEALTHCARE PROVIDERS

Primary Health Care Physician:_____Phone: _____

When was your child's last physical exam? _____

Is he/she currently under the care of a specialist? _____

Name:_____Specialty:_____Phone: _____

Name:_____Specialty:_____Phone: _____

List your child's primary health concerns, in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

HEALTH HISTORY

How would you describe your child's general state of health? Excellent Good Fair Poor

Is your child currently being treated for a health concern by other healthcare practitioners? Please explain.

_____

_____

Does your child have any known contagious diseases at this time? Y N If yes, what?

_____

List any serious conditions, illnesses, injuries, surgeries, and/or hospitalizations that your child has experienced, along with the approximate date.

	Date		Date

List any X-rays, CT scans, blood work or other studies (hearing, vision, etc.) that your child has had, along with the approximate date.

Study	Date	Study	Date

MEDICATIONS

Vitamins and Supplements

Please list all vitamin/mineral supplements, herbs, and homeopathic remedies you are currently taking:

Supplement (include brand)	Total daily dose	Reason for Use	Duration of Use

Prescription Medications

Please list all current medications and indicate the total dosage taken in one day:

Current Medications	Total daily dose	Reason for Use	Duration of Use

How many times has your child received antibiotics in the past three years? _____

Prescription Medications

Is your child sensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental agents? _____

Any chemicals? _____

Any supplements? _____

Has your child ever had an anaphylactic reaction? _____

Illnesses

What illnesses has your child had?

Scarlet fever____Diphtheria_____Rheumatic fever_____Mumps_____Measles_____German measles (rubella) ____

Chicken pox____Impetigo_____Tuberculosis_____Mononucleosis_____Strep throat_____Ear infections ____

Immunizations

What immunizations has your child had?

Hep B	Rotavirus
DTaP	Hib
PCV	IPV
MMR	Varicella
Hep A	HPV
MCV	Hep C
Smallpox	TB
Influenza	Other:

Please indicate if any immunizations caused adverse reactions _____

Family History

Does your child have a family history that includes any of the following? (Please circle and note Father, Mother, Maternal Grandmother/Grandfather, Paternal Grandmother/Grandfather, Sibling, etc.)

Alcoholism or Drug Addiction_____

Cancer (list type)_____

High Blood Pressure_____

Heart Disease_____

Heart Attack_____

Stroke_____

Anxiety or Depression_____

Other Mental Illness_____

Diabetes_____

Thyroid Disorder_____

Other Endocrine Disorder_____

Asthma_____

Tuberculosis_____

Other Respiratory Disorder_____

Allergies_____

Autoimmune Disease_____

Other Immune Disorder_____

Osteoporosis_____

Other Bone Disorder_____

Does your child have any other significant family history that Dr. Hawkins should consider?

Prenatal Health

What was the health of the parents at conception?

Mother: Poor Fair Good Excellent Unknown

Father: Poor Fair Good Excellent Unknown

What was the health of the mother during the pregnancy? Poor Fair Good Excellent Unknown

What was the mother's age at child's birth? _____

Did the mother experience any of the following during pregnancy:

Bleeding____High blood pressure_____Nausea_____Vomiting ____

Diabetes____Thyroid problems_____Physical/emotional trauma ____

Other _____

Did the mother use any of the following during pregnancy? If so, please list amounts, frequency:

Medications Y N _____

Tobacco Y N _____

Recreational drugs Y N _____

Prescription medications Y N _____

Supplements Y N _____

Birth History

Term length: Full Premature:_____wks Late:_____wks

Length of labor:_____Weight at birth: _____

Any complications? _____

Was the birth: Vaginal/C-section_____Induced_____Forceps_____Anesthesia used _____

In the first few weeks, did the child experience any of the following (circle all that apply)?

congenital birth defects colic constipation vomiting

jaundice rashes seizures other _____

Age at first: sitting_____crawling_____teething_____walking_talking _____

Diet

Was your child breast fed? Y N If, so for how long? _____

At what age did you introduce solid foods? _____

Are there any foods you exclude from your child's diet? If so, for what reason?

_____

Are there any foods your child craves (chocolate, sweets, salty, rich/fatty, breads, spicy)? _____

How much water does your child drink daily? _____

How often does your child have a bowel movement? _____

Lifestyle

How is your child's energy?_____Stress level? _____

Does your child exercise regularly?_____How often?_____What type? _____

Is your child regularly exposed to toxins or other hazards (school, home, hobbies, etc.)? Please describe.

How many hours of sleep does your child typically get? _____

Any problems with sleep? _____

Describe your child's temperament:

How does your child feel about school/day-care?

What are your child's main interests and hobbies?

How would you describe the emotional climate of your home?

Is there anything else that you would like to share that has not been covered?