CUTLER INTEGRATIVE MEDICINE

CHILD INTAKE FORM

This form is completely confidential. Please submit by email, fax, mail, or in-person **3 business days** before your appointment..

PROFILE:

Child's Name: _____ Gender: ☐ M ☐ F Age: _____

Today's Date: _____/_____/_____ (dd/mm/yyyy) Date of Birth: _____/_____/_____ (dd/mm/yyyy)

Parent's Name: _____

Address: _____

_____

Telephone: (Home) _____-_____-_____ (Cell) _____-_____-_____ (Work) _____-_____-_____

Prefer Email Correspondence? ☐ Y ☐ N Email: _____

Parent's Occupation: _____ Employer: _____

Marital status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Child's Siblings / Ages: _____

How did you hear about us? _____

May we give you appointment reminder calls? ☐ Y ☐ N (phone) _____-_____-_____

May we leave you phone messages? ☐ Y ☐ N (phone) _____-_____-_____ ☐ same as above

EMERGENCY CONTACT:

Name: Relationship:
Telephone: (home) _____-_____-_____ (cell) _____-_____-_____ (work) _____-_____-_____

MEDICAL CONTACTS:

Name of Medical Doctor / Family Physician:

Telephone: _____-_____-_____

Date of last blood work: Date of last annual / physical exam:

List any other health care providers (name, specialty, telephone):

MEDICAL HISTORY:

List child's health concerns in order of importance:

1. _____

2. _____

3. _____

4. _____

5. _____

Has any health concern recently changed or become worse? ☐ Y ☐ N

_____

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

What has your doctor (currently & previously) diagnosed your child with?

_____

_____

Please list all current medications (prescription or over-the-counter) and supplements (herbs, vitamins)

Name of Drug / Supplement	Used For	Date Started	Dose / Frequency

List past prescription medications: _____

_____

_____

List any known allergies (include drugs, food, environmental, chemical and etc.) and the reaction(s) from them.

_____

_____

Has your child undergone any type of allergy and/or food sensitivity testing? ☐ Y ☐ N

If yes, what kind of testing and the results: _____

_____

Child's Present Weight: _____

Child's Weight (1 year ago): _____

Child's Present Height: _____

PRE-NATAL HEALTH:

What was the parent's health at conception? (*sperm joining egg*)

Mother: ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Other: _____

Father: ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Other: _____

Mother's age at child's birth: _____ Did the mother receive pre-natal medical care? ☐ Y ☐ N

Mother's first pregnancy: ☐ Y ☐ N Child's birth order: ☐ First ☐ Last ☐ Middle ☐ Only

Mother's health during pregnancy: ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Other: _____

Did the mother experience any of the following during pregnancy:

☐ Bleeding ☐ Diabetes ☐ Nausea ☐ Vomiting ☐ High blood pressure ☐ Thyroid issues

☐ Physical or Emotional trauma ☐ Other: _____

Did the mother use any of the following during pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational drugs ☐ Antibiotics ☐ Other: _____

BIRTH HISTORY:

Term length: ☐ Full ☐ Premature _____ weeks ☐ Late _____ weeks

Birth weight: _____ lbs. _____ oz. Birth Length: _____

Method of delivery: ☐ Vaginal ☐ C-section ☐ Induced ☐ Forceps ☐ Anesthesia used

List any complications during labor: _____

_____

Did the child experience any of the following at/or shortly after birth:

☐ Jaundice ☐ Rashes ☐ Seizures ☐ Other: _____

_____

_____

_____

_____

_____

List any traumas (mental, emotional, physical), injury, illness, surgery or hospitalizations:

Incident	Date	Long-term effects

Note when and why your child has had any of the following:

X-Rays:		**MRI:**	
Ultrasounds:		**CAT Scans:**	
Tuberculosis Test:		**Last Dental Work:**	
HIV Test:		**Last Eye Exam:**	

CHILDHOOD ILLNESSES: (*check all that apply*)

☐ Chicken pox ☐ Measles ☐ Mumps ☐ Rubella ☐ Rheumatic fever

☐ Scarlet fever ☐ Tuberculosis ☐ Pertussis ☐ Asthma ☐ Seasonal Allergies

☐ Ear Infections Total Ear Infections (in 1 year): _____

☐ Colds Total Colds (in 1 year): _____

☐ Strep Throat Total Strep Throats (in 1 year): _____

☐ Other: _____

How many times has your child been treated with antibiotics? _____

For what condition(s): _____

_____

Has your child ever used probiotics after antibiotic use? ☐ Y ☐ N _____

VACCINATIONS: (*check all that apply*)

☐ DPT (diptheria, pertussis, tetanus) ☐ HIB (haemophilus influenze B) ☐ Small pox ☐ Varicella (chicken pox)

☐ MMR (measles, mumps, rubella) ☐ Polio ☐ Gardasil (HPV) ☐ Hepatitis A

☐ Hepatitis B ☐ Seasonal Flu shot ☐ Tetanus Booster ☐ RotaVirus

☐ Meningococcal ☐ Pneumococcal ☐ Unknown

Adverse reactions to any vaccines (what you witnessed, not what you were told "couldn't possibly happen"): ☐ Y ☐ N

If yes, please explain: _____

_____

FAMILY HISTORY:

Please indicate if your child's immediate family has had any of the following conditions:

Condition	Family Member(s)	Condition	Family Member(s)
Alcoholism / Drug abuse		Epilepsy	
Allergies / Hayfever		Heart disease	
Arthritis		High blood pressure	
Asthma / Emphysema		Kidney disease	
Auto-immune disease		Liver disease	
Bleeding disorder		Mental illness	
Cancer		Overweight / Obesity	
Diabetes		Stroke	
Digestive disorder		Thyroid problems	
Eating disorder		Other:	

☐ Don't know child's family medical history: (*please explain why*) _____

_____

DEVELOPMENT / DIET / DIGESTION / LIFESTYLE / ENVIRONMENTAL:

At what age did your child first: Sit up: _____ Crawl: _____ Walk: _____ Talk: _____

How many hours does your child sleep nightly? _____

Is your child: ☐ At home ☐ In daycare ☐ In school and Grade: _____ ☐ Other: _____

How would you describe your child's temperament? _____

How would you describe your child's energy? _____

How would you describe the emotional climate of the child's home? _____

How would you describe your child's behavior and performance at school? _____

What are your child's favorite activities? _____

_____

How much television does your child watch? (hours a day/week) _____

Does your child exercise regularly? ☐ Y ☐ N Type: _____

How is/was your child fed? ☐ Breastfed and Duration: _____ ☐ Formula and Type: _____ ☐ Other: _____

Has your child ever experienced colic? ☐ Mild ☐ Moderate ☐ Severe

What foods were introduced before 6 months of age (please list approximate months as well): _____

What foods were introduced between 6 and 12 months of age: _____

List any food allergies / sensitivities: _____

Child exposed to environmental pollutants? ☐ Y ☐ N ☐ Unknown

Child exposed to tobacco smoke? ☐ Y ☐ N

Child frequently exposed to animals? ☐ Y ☐ N

(Y = current / N = never / P = past)

Nightmares:	☐ Y ☐ N ☐ P	Sleepwalk:	☐ Y ☐ N ☐ P
Wake Refreshed:	☐ Y ☐ N ☐ P	Must nap during the day:	☐ Y ☐ N ☐ P
Grind teeth:	☐ Y ☐ N ☐ P	Snore:	☐ Y ☐ N ☐ P

Please record your child's diet for the last 3 days:

	Day 1	Day 2	Day 3
Breakfast			
Lunch			
Dinner			

Does your child have dietary restrictions (religious, vegetarian, vegan)? ☐ Y ☐ N _____

How many ***ounces*** of water does your child drink per day? _____ What type of water? _____

How often are your child's bowel movements? _____

Do they tend towards? ☐ Constipation ☐ Diarrhea ☐ Both ☐ Other: _____

What is the color of the stool? _____ Any undigested food in stool? ☐ Y ☐ N

What is the shape of the stool? ☐ Well-formed ☐ Ribbon-like ☐ Pellets ☐ Other: _____

History of bed-wetting? ☐ Yes ☐ No

History of sexual, mental/emotional or physical abuse? ☐ Y ☐ N

If so, at what age and by whom? _____

_____

What is your child's greatest health concern? _____

How does it limit them the most? _____

How committed are you & your child towards making valuable changes? ☐ Little ☐ Moderate ☐ Very ☐ Don't Know

REVIEW OF SYMPTOMS:

(Y = current / N never / P = past) *(Check all that apply)*

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
Cancer:	☐ Y	☐ N	☐ P		Perspiration	☐ Y	☐ N	☐ P
HEAD								
Headache:	☐ Y	☐ N	☐ P		Migraine:	☐ Y	☐ N	☐ P
Dandruff:	☐ Y	☐ N	☐ P		Head injury:	☐ Y	☐ N	☐ P
Oily / dry hair:	☐ Y	☐ N	☐ P		Hair loss:	☐ Y	☐ N	☐ P
NOSE								
Frequent Colds:	☐ Y	☐ N	☐ P		Nosebleeds:	☐ Y	☐ N	☐ P
Congestion:	☐ Y	☐ N	☐ P		Post nasal drip:	☐ Y	☐ N	☐ P
Polyps:	☐ Y	☐ N	☐ P		Seasonal Allergies:	☐ Y	☐ N	☐ P
EYES								
Dry / Watery:	☐ Y	☐ N	☐ P		Blurry Vision:	☐ Y	☐ N	☐ P
Double Vision:	☐ Y	☐ N	☐ P		Cataracts:	☐ Y	☐ N	☐ P
Glaucoma:	☐ 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
MOUTH / THROAT								
Canker sores:	☐ Y	☐ N	☐ P		Cold sores:	☐ Y	☐ N	☐ P

Sore throat:	☐ Y	☐ N	☐ P		Gum disease:	☐ Y	☐ N	☐ P
Dentures:	☐ Y	☐ N	☐ P		Cavities:	☐ Y	☐ N	☐ P
Loss of tastes:	☐ Y	☐ N	☐ P		Hoarsness:	☐ 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
URINARY TRACT								
Incontinence:	☐ Y	☐ N	☐ P		Pain w/ urination	☐ Y	☐ N	☐ P
Frequent Infections:	☐ Y	☐ N	☐ P		Kidney Stones	☐ Y	☐ N	☐ P
Urgency	☐ Y	☐ N	☐ P		Discharge / blood	☐ Y	☐ N	☐ P
GASTROINTESTINAL								

Heartburn:	☐ Y	☐ N	☐ P		Parasites	☐ Y	☐ N	☐ P
Indigestion:	☐ Y	☐ N	☐ P		Blood in stool	☐ Y	☐ N	☐ P
Bloating:	☐ Y	☐ N	☐ P		Diarrhea	☐ Y	☐ N	☐ P
Nausea:	☐ Y	☐ N	☐ P		Constipation	☐ Y	☐ N	☐ P
Vomiting:	☐ Y	☐ N	☐ P		Liver disease:	☐ Y	☐ N	☐ P
Change in appetite:	☐ Y	☐ N	☐ P		Gall bladder disease	☐ Y	☐ N	☐ P
Pancreatitis:	☐ Y	☐ N	☐ P		Ulcer	☐ Y	☐ N	☐ P
MUSKULOSKELETAL								
Weakness:	☐ Y	☐ N	☐ P		Arthritis:	☐ Y	☐ N	☐ P
Stiffness:	☐ Y	☐ N	☐ P		Leg cramps:	☐ Y	☐ N	☐ P
Tremors:	☐ Y	☐ N	☐ P		Growing Pains:	☐ Y	☐ N	☐ P
NERVOUS SYSTEM								
Paralysis:	☐ Y	☐ N	☐ P		Sciatica:	☐ Y	☐ N	☐ P
Tingling / numbness:	☐ Y	☐ N	☐ P		Carpal tunnel:	☐ Y	☐ N	☐ P
Seizures:	☐ Y	☐ N	☐ P		Fainting:	☐ Y	☐ N	☐ P
MENTAL / EMOTIONAL								
Depression:	☐ Y	☐ N	☐ P		Anger / Irritability	☐ Y	☐ N	☐ P
Suicidal:	☐ Y	☐ N	☐ P		High strung/ tense	☐ Y	☐ N	☐ P
Anxiety	☐ Y	☐ N	☐ P		Fear / Panic:	☐ Y	☐ N	☐ P
Eating disorder:	☐ Y	☐ N	☐ P		Speech Impediment	☐ Y	☐ N	☐ P
PTSD	☐ Y	☐ N	☐ P		Learning Impediment	☐ Y	☐ N	☐ P

What potential obstacles do you foresee in addressing the lifestyle factors, which are undermining your child's health, and in adhering to the therapeutic protocols?

_____

_____

_____

What are your goals and expectations after your child's first new patient visit with Dr. Cutler?

_____

_____

_____

Is there any other information that you feel is important that has not been covered?

_____

_____

_____

Thank you very much for taking the time to complete this thorough form.
It will greatly assist in the formulation of an individualized protocol specific to your healthcare needs