TREE OF LIFE WELLNESS

# Intake Form

## General Information

Name: Age: Prounouns:

Date of Birth: Email:

Address: City:

Phone (Home): Cell:

Background: ☐ African ☐ European ☐ Mediterranean ☐ Asian ☐ Native American ☐ Other ☐ Middle Eastern

Emergency Contact #1: Relationship:

Phone (Home): Cell:

Emergency Contact #2: Relationship:

Phone (Home): Cell:

When, where and from whom did your child last receive medical or health care?

Physician/practitioner (Name): (Phone): (Fax):

Primary Pharmacy

Name: Phone Number:

Address: City: State:

Zip: E-mail: Fax*:

Insurance:

Carrier Name: _____

Enrollee ID/Contract Number: _____

Group Number: _____

# Health History

Please list any current health concerns you have for your child:

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

## Medications/Supplements

Current medications (include prescription and over-the-counter)

| Medication | Dosage | Start Date | Reason for Use |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Nutritional supplements (vitamins/minerals/herbs etc.)

| Name/Brand | Dosage | Start Date | Reason for Use |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Have medications or supplements ever caused unusual side effects or problems? If yes, describe: ☐ Yes ☐ No

## Allergies

| Name of Medication/Supplement/Food: | Reaction: |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

Birth and Development History:

Patient was born via:
__ Vaginal delivery
__ Cesarean delivery

Complications during pregnancy, please describe:

_____
_____
_____

Complications during birth/delivery, please describe:

_____
_____
_____

To this point, has your child had any growth or developmental delays, please describe:

_____
_____
_____
_____

Do you have any concerns about your child's behavior, food intake, sleep, or digestion, please describe:

_____
_____
_____
_____

Are there any specific topics that would cause your child anxiety to discuss or anything else specific that would be helpful for me to know about your child, please list/describe below:

_____
_____
_____
_____
_____
_____

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# Family History

Check family members that have/had any of the following

| | Mother | Father | Brother (s) | Sister (s) | Child | Child | Child | Child | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Age (if still alive) | | | | | | | | | | | | | |
| Age at death (if deceased) | | | | | | | | | | | | | |
| Cancer | o | o | o | o | o | o | o | o | o | o | o | o | o |
| Heart disease | o | o | o | o | o | o | o | o | o | o | o | o | o |
| Hypertension | o | o | o | o | o | o | o | o | o | o | o | o | o |
| Obesity | o | o | o | o | o | o | o | o | o | o | o | o | o |
| Diabetes | o | o | o | o | o | o | o | o | o | o | o | o | o |
| Stroke | o | o | o | o | o | o | o | o | o | o | o | o | o |
| Autoimmune disease | o | o | o | o | o | o | o | o | o | o | o | o | o |
| Arthritis | o | o | o | o | o | o | o | o | o | o | o | o | o |
| Kidney disease | o | o | o | o | o | o | o | o | o | o | o | o | o |
| Thyroid problems | o | o | o | o | o | o | o | o | o | o | o | o | o |
| Seizures/epilepsy | o | o | o | o | o | o | o | o | o | o | o | o | o |
| Psychiatric disorders | o | o | o | o | o | o | o | o | o | o | o | o | o |
| Anxiety | o | o | o | o | o | o | o | o | o | o | o | o | o |
| Depression | o | o | o | o | o | o | o | o | o | o | o | o | o |
| Asthma | o | o | o | o | o | o | o | o | o | o | o | o | o |
| Allergies | o | o | o | o | o | o | o | o | o | o | o | o | o |
| Eczema | o | o | o | o | o | o | o | o | o | o | o | o | o |
| ADHD | o | o | o | o | o | o | o | o | o | o | o | o | o |
| Autism | o | o | o | o | o | o | o | o | o | o | o | o | o |
| Irritable Bowel Syndrome | o | o | o | o | o | o | o | o | o | o | o | o | o |
| Dementia | o | o | o | o | o | o | o | o | o | o | o | o | o |
| Substance abuse | o | o | o | o | o | o | o | o | o | o | o | o | o |
| Genetic disorders | o | o | o | o | o | o | o | o | o | o | o | o | o |
| Other: | o | o | o | o | o | o | o | o | o | o | o | o | o |