North Macon Wellness Therapy
Pediatric Comprehensive Functional Medicine Intake

Patient Information

Full Name: _____

Date of Birth:_____
Sex: ☐ M ☐ F ☐ Other ☐

Address:_____

Phone Number:_____

Email:_____

Emergency Contact Name, Relationship & Phone:

_____

Reason for Visit

What are your main health concerns/goals for this visit?
(Include both physical and emotional/mental concerns.)

1.

2.

3.

When did these issues begin?

What has your child tried so far?
☐ Medications
☐ Supplements
☐ Lifestyle changes

☐ Therapy
☐ Other: _____

How would you rate your child's current overall health?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Developmental History

Pregnancy & Birth Concerns:

Full-term? [ ] Yes [ ] No
Vaginal/C-Section? _____ Birth weight: _____ lbs

Milestones (e.g., crawling, walking, talking):

Any developmental delays?

Vaccination & Screening History

Up to date on vaccinations? [ ] Yes [ ] No
Date of last physical exam: _____
Vision screening: _____
Hearing screening: _____
Dental exam: _____
Any past imaging (e.g., X-rays, MRI)?

Family & Social History

Primary caregivers:

_____

Siblings and ages:

_____

Parental occupations:

_____

Any family history of chronic illness (asthma, ADHD, allergies, autoimmune, etc)?

Home environment (pets, smoking, mold, etc.):

Current Healthcare Team

Primary Care Provider Name & Location:

Other Practitioners Your Child Sees Regularly:

☐ Chiropractor
☐ Naturopath
☐ Therapist
☐ Specialist(s): _____

Surgeries/Hospitalizations (with dates):

Major Injuries/Accidents (with dates):

Does your child have a family history of any chronic illnesses?

☐ Heart Disease
☐ Diabetes
☐ Cancer
☐ Autoimmune Disorders
☐ Mental Health Conditions
☐ Other: _____

Medications & Supplements

Current Medications (Rx or OTC):

Name	Dose	Frequency	Purpose

Current Supplements or Herbs:

Name	Dose	Frequency	Purpose

Medication Allergies/Sensitivities:

Food Allergies or Sensitivities:

Lifestyle & Environment

Sleep

- Hours per night: ___
- Quality: ☐ Good ☐ Fair ☐ Poor
- Trouble falling or staying asleep? ☐ Yes ☐ No

Diet

- How would you describe your child's typical diet?
- Does your child follow a specific eating pattern?

- Number of meals per day: __

Exercise

- Type:
- Frequency: ___ days/week
- Duration per session: ___ minutes

Stress & Mental Health

- Stress level (1–10): ___
- Main stressors:

- Mental health history (anxiety, depression, PTSD, etc.):

Social & Emotional Support

- Is your child in a safe living situation?
- Any major recent life events?

Environment

- Does your child have mold or chemical exposure at home or school?
- Pets in the home?
- Water source: ☐ Filtered ☐ Tap ☐ Well

Body Systems Review *(Check all that apply)*

Energy & Sleep
- ☐ Fatigue
- ☐ Insomnia
- ☐ Snoring
- ☐ Daytime drowsiness

Skin & Hair
- ☐ Rashes
- ☐ Acne
- ☐ Eczema/Psoriasis
- ☐ Hair thinning/loss

Head, Eyes, Ears, Nose, Throat
- ☐ Headaches
- ☐ Sinus issues
- ☐ Vision changes
- ☐ Ringing in ears

Respiratory
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Chronic cough

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations
- ☐ High blood pressure

Digestive
- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Food intolerances

Urinary/Reproductive
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Menstrual irregularities
- ☐ Libido changes
- ☐ Sexual dysfunction

Musculoskeletal
☐ Joint pain
☐ Muscle weakness
☐ Back/neck pain

Neurological
☐ Dizziness
☐ Memory issues
☐ Numbness/tingling

Mood & Mental Health
☐ Anxiety
☐ Depression
☐ Mood swings
☐ Brain fog

Functional Timeline (Optional)

Please list major life events, illnesses, traumas, or turning points in your child's health (e.g., childbirth, major stress, surgeries) by decade or age range.

Anything Else You'd Like Us to Know?