NEW
Natural Elite Wellness

PEDIATRIC INTAKE FORM

PATIENT INFORMATION **DATE** _____

Last Name _____ **First Name** _____
Middle Initial _____**Gender** ☐ **M** ☐ **F** **Date of Birth** _____**Age** _____
Mother's Name:_____**Father's Name:**_____
Address_____**Zip code**_____
Home phone (____**)**_____ **Cell phone (**____**)**_____**Work phone (**___**)**_____
May we leave a message? ☐ **Y** ☐ **N** **Preferred phone** _____ **Email**_____
Parents' Marital Status: ☐ **Single** ☐ **Married** ☐ **Partner** ☐ **Divorced** ☐ **Widowed** ☐ **Separated**
Grade in School:

How did you hear about us? _____

HEALTH COMPLAINTS (please list in order of importance to you):

Complaint	Duration	Cause

Are You Currently Under the Care of a Primary Care Physician (PCP), Medical Doctor (MD), or Other Health Care Practitioner (ND, DC, DO, etc)?

Name	For What Conditions?	Treatment?

What MEDICATIONS Are You Currently Taking? (please list prescription and over-the-counter drugs you are currently taking or have taken for extended periods):

Medication	Reason	Dose & Duration	Adverse Effects

List any allergies to medications:_____

Simona Ciobanu, ND 1010 Jorie Blvd. Suite 112 Oak Brook, IL 60523 Phone: 630.251.4994
2732 N Clark, Suite 200 Chicago, IL 60614

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Have you taken prolonged courses of antibiotics? ☐ Y ☐ N

What SUPPLEMENTS Are You Currently Taking? (please list all vitamins, minerals, homeopathic remedies, botanicals, herbs, teas, etc.)

Supplement	Reason	Dose & Duration	Effect

List any allergies/sensitivities/adverse reactions to supplements: _____

_____

Please list any HOSPITALIZATIONS, SURGERIES, MAJOR ACCIDENTS, AND TRAUMATIC EVENTS (physical and/or emotional):

Event	Effect	Date

PAST DIAGNOSTIC PROCEDURES:

Procedure	Date	Reason	Results
Basic Blood Work (CBC, CMP)			
Urinalysis			
Thyroid (TSH, T3, T4)			
Cholesterol			
Vit D			
Pap Smear			
Colonoscopy			
CT Scan, MRI			
X-ray, Ultrasound			
Vision			
Dental			
Other			

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Which of the Following CONDITIONS Have You Had:

	Allergies		Asthma		High cholesterol		Jaundice		Hormonal imb.
	Anxiety		Hay Fever		Frequent UTI		Hepatitis		Diabetes
	Depression		Mono		Kidney Stones		Gastritis		Leukemia
	Bipolar		Influenza		Incontinence		Gall Stones		Alcoholism
	Migraine		Cold Sores		Heartburn/GERD		Kidney disease		Tuberculosis
	Ear infection		Sinusitis		Ulcer		Gout		Skin Disease
	Tonsillitis		High BP		Constipation		Joint pain		Prostatitis
	Strep Throat		Low BP		Diarrhea		Joint stiffness		Cancer
	Pneumonia		Chest Pain		Chron's Disease		Arthritis		Parasites
	Bronchitis		Palpitation		UlcerativeColitis		MS		STD/STI
	Cough		Rheumatic fever		IBS		Hypothyroidism		Bleeding
	Wheezing		Stroke		Nausea/Vomit		Hyperthyroidism		Epilepsy

FAMILY MEDICAL HISTORY: please list any ailments your blood relatives have had:

	Mother	Father	Siblings	Grandparents	Aunts/Uncles	Children
Age if living						
Age at death						
Ailments						

Please Indicate your BLOOD TYPE:

A	☐
B	☐
AB	☐
O	☐

Please Indicate Your VACCINATIONS:

Hepatitis	☐
MMR	☐
Chicken Pox	☐
Meningitis	☐
Polio	☐
Tetanus	☐
Influenza	☐
HPV	☐
Whooping Cough	☐

Other(s): _____

Any Vaccination Reaction? _____

_____

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PREGNANCY, BIRTH, and DEVELOPMENT:

Mother's Health During Pregnancy:_____
Medications During Pregnancy:_____
Stresses During Pregnancy:_____
Pregnancy Length:_____**Pregnancy #**_____**Type of Delivery:** ☐ **Vaginal** ☐ **Cesarean**
Labor: ☐ **Spontaneous** ☐ **Induced** **Delivery Location:**_____
Delivery Complications:_____
Birth Weight:_____**Apgar Score:**_____**Newborn Problems**_____
Feeding History/Problems:_____**If Breastfed, how long**_____
If Bottle Fed, What Formula_____**Age of 1st Solid Food**_____
Developmental Milestones: ☐ **Walked**_____ ☐ **Talked**_____ ☐ **1st Teeth**_____
Peculiar Habits or Behavior:

DIET and NUTRITION ASSESSMENT:

As accurately as possible, please list all food and drink consumed in the last 2 days:

MEAL	DAY 1	DAY 2
Breakfast		
Lunch		
Dinner		
Snacks/Dessert		
Drink		

ENVIRONMENTAL

Please List any Environmental/Chemical Exposures and Reactions:

Substance	Exposure	Reaction
Lead		
Pollen/Ragweed/Trees/Animals		
New Paint, Carpet		
Second-hand Smoke		
Mold		
Radiation		
Detergents/Dry cleaning		

How can I best be of service to you? Do you have any special requests or goals in regards to your treatment that I should know of? _____
_____
_____

I, _____**Certify that the above information is true and accurate to the best of my knowledge. I understand that any false health information or withholding of health information can be detrimental to my health and I hold no liability against Dr. Simona Ciobanu, ND.**

_____ _____
Patient or Responsible Party Signature Simona Ciobanu, ND

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